Workforce to profession: an exploration of New Zealand Midwifery's professionalising strategies from 1986 to 2005

By

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Certificate of authorship/originality

I certify that the work in 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.

I also certify that the thesis has been written by me except where made explicit that a portfolio piece has been co-authored. Any help I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Abstract

Over the last twenty years New Zealand midwives have worked to reclaim their professional autonomy and scope of practice in order to promote a women-centred and midwife-led maternity service. In order to achieve these aims New Zealand midwifery engaged in several key professionalising strategies that have proved successful in developing midwifery as a recognised profession with a social mandate to provide autonomous midwifery care to women throughout pregnancy, labour, birth and the postnatal period. These strategies were integrated but can be defined separately as: partnership relationships with women; leadership through the professional organisation; education for midwifery autonomy, and self-regulation within midwifery professional frameworks.

Through an exploration of key midwifery professionalising strategies this doctorate identifies the unique characteristics and development of midwifery in New Zealand and critically reflects on the success and ongoing challenges of its integrated professionalising strategies.

Introduction

This thesis chronicles the development of the midwifery profession in New Zealand. It explores four key professionalising strategies that led midwifery from workforce to profession. These are: partnership relationships with women; leadership through the professional organisation; education for midwifery autonomy and self-regulation within midwifery professional frameworks. Midwifery partnership with women is the philosophical foundation to midwifery in New Zealand. Whilst the notion of partnership is not in itself unique, it is the contention that midwifery is a partnership and the congruence of partnership in practice, policy, education, politics and regulation that defines the unique contribution of New Zealand midwifery.

The last twenty years have seen resurgence in midwifery in New Zealand as midwives have worked to reclaim their professional autonomy and scope of practice in order to promote a women-centred and midwife-led maternity service. In order to achieve these aims midwifery needed to move from a workforce to a profession so it could exercise its professional power to claim its area of expertise – normal pregnancy and childbirth, and thus identify its point of difference from other professional groups engaged in provision of maternity services, such as medicine and nursing.

New Zealand midwifery engaged in several key professionalising strategies that have proved successful in developing midwifery as a recognised profession with a social mandate to provide autonomous midwifery care to women throughout pregnancy, labour, birth and the postnatal period. These strategies of partnership, leadership, education and regulation were integrated in their operation but for the purposes of exploration will be discussed separately. Underpinning each of these strategies is the philosophical belief that women should be in control of their own birthing experiences and that in order to facilitate this, midwifery needs to be control of itself as a profession (Guilliland and Pairman, 1995). Thus midwifery works to achieve autonomy and self-determination for both childbearing women and midwives.

The aim of this professional doctorate is to assist midwives to understand what it means to be part of the midwifery profession in New Zealand through an exploration of key midwifery professionalising strategies. By examining midwifery partnership, midwifery leadership, midwifery education, and midwifery regulation this doctorate identifies the unique characteristics and development of midwifery in New Zealand and critically reflects on the success and ongoing challenges of its integrated professionalising strategies.

In introducing this doctoral work I will first provide an overview of the thesis and the ordering of its various parts so as to provide a map for the reader. This is followed by a discussion of the location of self within this work and explores my interest in the topic and my relationship with the work through my professional practice. This introduction does not introduce writers who have influenced the theoretical underpinning to my thinking but they will be exposed through discussion of the body of work. Part One, the theoretical framework for the thesis, follows the introduction.

Overview of Thesis

The thesis comprises six parts. Part One provides the theoretical framing for the thesis and comprises two chapters. Chapter One provides background to the thesis through discussion of the reasons why New Zealand midwifery sought professional status. It continues with exploration of notions of profession, professionalisation and professionalism from a theoretical perspective. Chapter Two draws on this theory in an examination of New Zealand midwifery's professional project. This chapter traces New Zealand midwifery's shifting professional status; from its limited autonomy in the early part of the 20th century, to its loss of professional autonomy as a workforce, to the reinstatement of autonomy and development as a profession. New Zealand midwifery achieved and consolidated its professional status through four integrated professionalising strategies. These four strategies were: partnership relationships with women; leadership through the professional organisation; education for midwifery autonomy and self-regulation within midwifery professional frameworks. Together these strategies provide an integrated professional framework through which midwifery's philosophical base is aligned with all its

professional processes. Following Part One are four more parts, each of which looks at a single professionalising strategy in more depth. The thesis is concluded in Part Six.

Part Two explores Midwifery Partnership as a key philosophy and practice that has enabled New Zealand midwifery to claim a unique professional identity in partnership with women. The theoretical framework of Midwifery Partnership (Guilliland & Pairman, 1995) underpins midwifery at every level in New Zealand. The Midwifery Partnership Model provides the framework for midwifery's professional structures, educational structures, and regulatory structures. Midwifery Partnership operates at the level of the individual midwife/woman, the professional organisation, the midwifery education programmes, and the midwifery regulatory authority. Partnership is integrated in every aspect of New Zealand midwifery's professional development.

Part Three focuses on the ways in which midwifery's professional organisation, the New Zealand College of Midwives, has provided leadership and direction in establishing and maintaining midwifery as a profession.

Part Four identifies the importance of education as a strategy for creating midwifery's professional identity and as a process for the professionalisation of midwives as they join the profession.

Part Five provides an overview of the recent establishment of the Midwifery Council of New Zealand as the regulatory authority for midwifery. With the formation of the Council and the implementation of its regulatory policies and processes, New Zealand midwifery now has an integrated professional, educational and regulatory framework underpinned by Midwifery Partnership. This framework provides a basis for the ongoing evolution of midwifery as a profession in New Zealand.

Part Six concludes the thesis with critical reflection on the success and ongoing challenges of the various professionalising strategies and argues the centrality of Midwifery

Partnership in shaping and changing midwifery practice in New Zealand. It also speaks to the original contribution made by this thesis to the body of knowledge that is midwifery.

Parts Two, Three, Four, and Five each comprise a discussion of a key professionalising strategy in relation to theory of profession, in order to examine how these strategies influenced the professionalisation of New Zealand midwifery. For each part a portfolio of individual works follows this discussion. The portfolio pieces provide a variety of individual works that explore aspects of each strategy. In line with the requirements of a professional doctorate these individual pieces were written as part of my professional practice as a doctoral student. Each portfolio is introduced by a foreword that explores the context and rationale for each of the related portfolio pieces, explaining why they were written and their location within the body of work.

Several portfolio pieces were the result of research into the historical development of the New Zealand College of Midwives and the development of midwifery education. This research involved locating and analysing historical records and verifying the findings and interpretations of this material with other midwives who also played key roles in these developments. Another piece reports research undertaken to identify the practice choices made by graduates of direct entry midwifery education programmes. Several pieces were written in partnership with midwife-colleagues and one reports research undertaken in collaboration with a final year midwifery student. Each piece was written in the style appropriate to its purpose and to the intended audience and this is made explicit in the foreword to each portfolio.

The intended audience for each piece is midwives and includes midwifery students as well as practising midwives. The thesis seeks to inform midwives of the context within which New Zealand midwifery has developed over the last twenty years, including the strategies employed to attain professional autonomy and create a unique professional identity. While the audience is primarily New Zealand midwives, the thesis also has relevance for midwives in other countries, particularly those with an interest in strengthening the professional status of midwifery in their countries and who may find the New Zealand

experience of benefit. For midwifery to maintain its professional status into the future midwives need to understand why professionalism is important, what makes New Zealand midwifery unique, how professional status was achieved, how contextual issues can impact on professional autonomy and practice, and what key strategies must be protected and strengthened in order for the profession to survive. This thesis seeks to explain these various aspects and to challenge midwives to develop further strategies to ensure the survival of midwifery for women.

Although presented in separate parts this thesis aims to create a unified 'whole' through the Introduction and Parts One and Six. While Parts Two to Five each focus on single professionalising strategies, Parts One and Six aim to integrate these strategies and present my exploration of the evolution of the midwifery profession in New Zealand as a single entity.

As required of the Doctor of Midwifery at University of Technology Sydney, this thesis focuses on professional issues of concern to midwifery internationally through scholarship that integrates and applies health policy and leadership with practice. The resulting portfolio represents a collection of smaller projects around the central theme of midwifery professionalism and integrates these through the dissertation which *"locates the work theoretically and explores the policy, leadership and international aspects of the work"* (White, 1999, p.25).

The positioning of self within the doctorate

I came to this doctoral work as a feminist woman and a mother, and most of all as a midwife with a passion for midwifery and a strong belief that it is possible to change the world (of childbirth and midwifery at least). I believe that childbirth is a fundamental life process that belongs to women and their families and to communities and of which women have the right to be in control. Childbirth is life changing and deeply meaningful to women as they create life, give birth to children, and become mothers. If that experience can be positive and fulfilling and empowering, then women are strengthened, families are

strengthened, and communities are strengthened. To me, midwifery is about facilitating a context in which childbirth and new mothering is transformative and empowering for women.

It is these beliefs that have driven my practice as a midwife for twenty-four years. However, I did not come to midwifery with these understandings. As the eldest of five I grew up with a strong sense of responsibility for myself and for others. Several teachers who were exploring notions of women's rights and patriarchal structures influenced my high school years at a single sex school in the early 1970s. I was taught that I could do anything and was encouraged to attend university. My university years were a privilege I did not fully appreciate at the time. Those were the years before student fees and student loans and I could throw myself into a student life that allowed me tremendous freedom to study subjects of interest with no real thought of a career at the end of it. I entered nursing after achieving a bachelor's degree in English literature, mainly because I saw it as providing a job with which I could travel. I was never happy as a nurse and rebelled against the hierarchy and task focus that I perceived. It was the final year course in obstetrics that sparked my interest in midwifery. I was strongly influenced by an enthusiastic and passionate midwife tutor who excited me with stories of domiciliary midwifery in London during the depression and I loved the idea of attending women in their homes. Not that I had any real idea of what this meant then because the only births I saw were in hospital, in theatres, with the woman under a spot light giving birth (with her legs in stirrups), her attendants dressed in green with masks and aprons and I was one of a row of students lined up against the wall to watch. I was appalled by the lack of privacy, yet fascinated by the process of birth and deeply in awe of the midwives who so competently and calmly managed everything.

The maternity unit was separate from the main hospital and the midwives seemed to have so much more autonomy than the nurses with whom I had worked. I was attracted to the work and to the way they conducted themselves in practice. My determination to become a midwife was cemented when, on holiday in Auckland (New Zealand's largest city), I was invited to attend the homebirth of a couple who were also staying with my friends. This

couple had come to Auckland from a rural area to access one of the few practising domiciliary midwives at the time, Joan Donley. This was a magical experience and unlike any birth I had witnessed to that time. It was gentle, quiet, peaceful and joyful. In the middle of the night there was a warm, softly lit room, a woman and her partner giving birth, numerous women supporters and this serene and confident midwife quietly facilitating the birth. That was it. I knew I wanted to be a midwife.

I managed to combine travel with my desire to become a midwife by moving to London to undertake midwifery training. And it was training. Clinical experience was gained alongside experienced midwives, mainly in hospital but with some amazing community and homebirth experiences. Theory was taught one day a week where we had to attend class in our uniforms. Our training in physiology, clinical skills and routines was solid but there was little discussion of women's experiences of birth, women's wishes, ethics or evidence-based care. There was, however, huge emphasis on midwifery autonomy and the knowledge and skills one needed to acquire in order to become a midwife and practise autonomously.

I graduated with a strong belief that midwives cared for women having normal births on their own responsibility and thus it was a shock to return to New Zealand in the early 1980s and find doctors involved in every birth. This was so obviously unnecessary, especially as it quickly became clear that doctors relied on midwives' judgements about women's progress and when the birth was imminent to enable them to get there in time and that in most cases they had no additional skill to offer women beyond what the midwife was already doing.

In the United Kingdom (UK) midwives had a legal right to practise autonomously and saw themselves as members of an autonomous profession separate to nursing. In New Zealand, midwifery was seen as a specialty of nursing and most midwives described themselves as nurses. Only domiciliary midwives had a limited legal right to practise autonomously and this was tempered with the requirement for a doctor to supervise every birth. My impression at that time was of a strong midwifery profession in the UK supported by an

identified midwifery education system; and a weak midwifery profession in New Zealand where both the profession and the education of midwives were completely subsumed by nursing.

At that time I lacked understanding of the influence of the socio-political contexts on midwifery practice in both countries and did not understand issues of medical dominance, power, or institutional hierarchies and the effect of these on autonomy. I was unaware of any significant challenge to these by the women's health movement or maternity consumer groups.

I was not exposed to any notion of feminism in my midwifery-training programme in the United Kingdom. Teaching focused on midwives as autonomous professionals and the childbearing woman was largely invisible. I didn't know anything about 'partnership' or 'power sharing' or 'women-centred' care, concepts that later became dear to my heart. I had a concern for women and cared about their experiences, but I saw those experiences as within my control as the midwife who 'managed' their care, rather than in the women's control. I did not understand at that time how the system I was part of took control away from women.

Returning to New Zealand challenged much of my thinking. For the first time I was exposed to maternity consumer groups demanding change. Women from Parents Centre (a consumer organisation) arrived at the hospital in labour with birth plans. Partners demanded to be present at their children's births. Women demanded rooming-in and demand-feeding for their babies. Parents Centre lobbied for more home-like birthing rooms. Consumers demanded and got an alternative birthing unit within the maternity hospital in Dunedin (a city in the South Island of New Zealand) that provided for a more 'natural' birth. Childbirth activist, Janet Balaskas, visited Dunedin and ran a workshop on active birthing for midwives and women that promoted upright and active positions for labour and birth and challenged the way that birth was managed in hospitals.

I loved it all. I began to see things differently and I worked hard to practise in a way that kept power with the woman and her family. I was the midwife who was always allocated the 'alternative life stylers', the women with the birth plans, the women who wanted to use the alternative birthing unit, the 'failed home-birthers' on transfer to the hospital. I learned a great deal from those women and from those birthing experiences. I worked with women who were clear about how they wanted their births to be and I began to understand childbirth as a women's issue and as an issue of power. I learned that birth could happen with little intervention from anyone and that the role of the midwife was to support the woman's wishes in this normal process.

This conviction that birth needed little intervention was strengthened when I joined with four other midwives to form the Dunedin Domiciliary Midwives Collective in 1988. By then I was working for Otago Polytechnic (an educational institution in the city of Dunedin) and teaching nursing students in the obstetric component of their nursing programme. However, when approached by several women seeking a midwife to provide homebirth care I joined with some midwifery colleagues to provide a homebirth midwifery service. Five of us formed the Collective. We all had full-time jobs but by sharing women's care we were able to provide domiciliary midwifery services for the increasing number of women wanting homebirth. We also managed to gain visiting staff status with the Area Health Board covering Dunedin and the greater Otago region, in order to provide continuity of care should any of our homebirth clients require transfer to hospital. The Collective was very successful and we continued to practise together until a full-time midwife was available to Dunedin women in 1990. Homebirth midwifery taught me much about autonomy, independence, women-centred care and power sharing; concepts that remain foundational to my own view of the world and beliefs about midwifery.

These practice experiences informed my political activity and helped shape my personal vision for midwifery. My political involvement began when I joined the Midwives Section of the New Zealand Nurses Association (NZNA) in 1984. The focus of the Midwives Section at that time was to create a separate identity for midwives and to have a voice within the larger nursing organisation. We also worked to achieve a separate one-year

midwifery programme for nurses and to have the International Confederation of Midwives Definition of a Midwife accepted by NZNA (see Parts Two and Three of this thesis for further discussion). This involvement in the Midwives Section enabled me to meet many midwives around New Zealand who influenced my thinking as a midwife.

The most significant of this group of midwives was Karen Guilliland. I first met Karen in 1986 at a tutor-training course and we immediately connected with each other. We were both midwives, both working for polytechnics and teaching nurses and both active members of our local Midwives Section. We both had a passion for midwifery and we quickly became friends. This friendship has been life changing and it is impossible to imagine now how my midwifery career would have evolved without my friendship with Karen. So much of our time together has been wrapped up in midwifery and we have influenced and shaped each other's thinking in so many ways. Karen has taught me about politics, about the 'big picture', and about feminist ways of working. Before I had my own children her patient's rights background and experiences as a mother brought another dimension to my understanding of midwifery autonomy and the midwife's role and we shared a vision of how midwifery could bring about change for women. This became a focus for our political activities.

In 1988 Karen and I represented the National Midwives Section at the annual NZNA conference and insisted on midwifery representation at forthcoming discussions on the future of midwifery education. We were instrumental in the decision to begin separate one-year midwifery programmes as an alternative to the existing midwifery option within the Advanced Diploma of Nursing.

Professionally this was the beginning of my career in midwifery education. Otago and Southland Polytechnics together were approved to run one of the first one-year programmes and I played a major role in the development of this curriculum and implementation of the programme. Midwifery students gained some homebirth experiences with the Dunedin Domiciliary Midwives Collective until it disbanded in 1990. Then, because there were few models of autonomous midwifery or continuity of care in existence in Dunedin, I

established the Otago Polytechnic Independent Midwifery Service (IMS) in 1991 with two colleagues. The IMS was very successful. It offered continuity of care to women for both home and hospital birth. Care was either midwife-only or shared with general practitioners. In most cases, where the woman agreed, a midwifery student would work alongside the midwife.

The experience of working autonomously as a midwife and providing continuity of care to women through my work with the Dunedin Domiciliary Midwives Collective and the Otago Polytechnic Independent Midwifery Service helped me to consolidate my vision of what a midwifery service should be. I believed that midwives should have their own caseload of clients and that they should work in small groups of no more than three to provide continuity of care. I thought that the ideal maternity service was where midwives would care for women having normal experiences and then collaborate with obstetricians when women had complications that needed specialist assistance. I thought that midwives could provide this type of independent care to women whether they worked in the community or were employed in hospitals, although I later came to appreciate how much employment and the institutional context of hospitals undermined autonomous midwifery practice. This is discussed further in Parts One and Two of this thesis.

Working in midwifery education helped me recognise the importance of education in shaping midwifery's identity and developing midwives with a midwifery philosophy and an understanding of concepts such as autonomy and responsibility. It was consumer activists such as Judi Strid who helped me realise the importance of direct entry midwifery education if midwifery was to make a significant difference to the childbirth experiences of women. Direct entry midwifery education provides a route to midwifery registration that does not first require a nursing qualification and nursing registration. The establishment of direct entry midwifery education clearly identified that midwifery and nursing were separate professions and that it was not necessary to be a nurse before becoming a midwife. In New Zealand in the 1980s it was mainly women and a few midwives who were promoting direct entry midwifery education and it was through their efforts that the majority of midwives later came to support direct entry midwifery education.

Working alongside women such as Judi with their clear vision of what midwifery could be was inspirational. So too were midwives like Joan Donley and Karen Guilliland who provided incredible leadership in both the political activity that led to the 1990 Nurses Amendment Act and the formation of the New Zealand College of Midwives in 1988/9. As the Chairperson of the Otago Region through the transition from Midwives Section to College Region I was privileged to be involved in these activities and I learned a great deal about working in partnership and what could be achieved through political action.

The opportunity for direct entry midwifery education arose from the 1990 legislative changes that enabled midwifery autonomy. I was instrumental in developing and establishing the first Bachelor of Midwifery degree in New Zealand and the first three-year degree programme world-wide. This gave me the opportunity to combine my ideas on midwifery practice and education in the development of a curriculum that focused on women-centred care, midwifery autonomy and partnership. The programme was commenced in 1992 and continues to this day.

In the years since, I have held a number of positions that have enabled me to play a significant role in shaping the midwifery profession we have today. I have been a midwifery educator since 1988, followed Karen as the second President of the New Zealand College of Midwives from 1992 to 1997, was a midwife member of the Nursing Council from 1997 to 2000 and was appointed as a member of the first Midwifery Council in 2003 and voted the inaugural Chair. To these roles I have brought my beliefs and understandings of midwifery and of childbirth and these beliefs have influenced the way in which New Zealand midwifery has implemented the professionalising strategies examined in this doctorate.

This insider view gave me a unique perspective from which to describe and explore the four key professionalising strategies that I have identified. My consistent involvement in midwifery's professional, educational and regulatory developments over the last twenty years allowed me to draw on extensive personal experience. The challenge was to find

ways to verify my personal recollections and interpretations. In the portfolio pieces that describe historical events and relate significant developments I have sought contemporaneous documentary evidence such as minutes of meetings, letters, records of phone calls, policy documents, newsletters, newspaper reports, curricula, government reports, and publications. These have been sourced from my own notes, my own records and my own documents, as well as archival material held by the New Zealand College of Midwives, the National Library, the Hocken Library, and the National Archives.

Two of the historical pieces on the College of Midwives were written in partnership with Karen Guilliland. As President and Director of the College respectively, we worked closely together in the formation and establishment of the College as the professional organisation for midwifery. Through writing these pieces together we could fill in different gaps and challenge each other's recollections. We clarified and explained our thinking at the time in order to demonstrate that the College worked from a strategy that took account of the socio-political context and was both responsive and proactive. We showed our work to other midwives who were involved at the time such as Norma Campbell, Bronwyn Pelvin and Glenda Stimpson, to see whether they thought our recollections and our analyses were accurate and we made changes as a result of their feedback.

One major strategy was the integration of the philosophy of partnership into the practice of midwifery and the structures and policies of the New Zealand College of Midwives. Although the College embraced partnership as a philosophy, an ethical stance and a standard for practice in 1988, it was not until Karen and I co-authored *The Midwifery Partnership: A Model for Practice* in 1995 that the notion of partnership began to be explored fully in midwifery. We developed a model that articulated how the philosophy of a partnership between a midwife and a woman could be implemented in midwifery practice. This model has been very influential and now underpins all midwifery curricula throughout New Zealand influencing both the way that midwifery education programmes are delivered to students and also the model of midwifery to which students strive.

Karen and I wrote the Midwifery Partnership Model as part of our course work for a Master of Arts in Midwifery degree at Victoria University Wellington. For the thesis component of this degree I carried out research that explored relationships between midwives and women working in caseloading continuity of midwifery care models (Pairman, 1998a). The results of this research suggested modifications to the original midwifery partnership model (Guilliland & Pairman, 1995), presented a revised model and introduced the notion of the midwife as a 'professional friend' (Pairman, 1998a).

Partnership continues to be examined and debated by midwives and women in New Zealand although Karen's and my work remains largely unchallenged. Our theoretical work on midwifery partnership provides a framework for autonomous midwifery practice in New Zealand. Part Two of this thesis contains a selection of work that further explores midwifery partnership and includes a piece jointly written by Karen and me that explains our reflections on the Midwifery Partnership Model ten years on.

In line with my philosophy of partnership, it has been important to write some of the portfolio pieces in partnership with Karen, particularly those that relate to our strategic leadership of the New Zealand College of Midwives and our work on the theoretical framework of Midwifery Partnership. However, this doctorate is my analysis of the professionalisation of midwifery in New Zealand since 1986 and I draw on the various portfolio pieces in this analysis of the professionalising strategies we employed. I cannot separate myself from these events because I shaped them as they shaped me. What I can do, however, is to try to step back and consider this work critically and pose some challenges for the midwives who come after us and who will take the profession forward.

This thesis now moves to Part One, which explores midwifery and professionalism. Part One comprises two chapters. The first examines why New Zealand midwifery needed to reclaim professional status and then moves to exploration of sociological theory of profession, professionalisation and professionalism that provides the theoretical framework for this thesis. The second chapter of Part One draws on this sociological theory in an exploration of New Zealand midwifery's professional project, including an overview the

four professionalising strategies that are further explicated in Parts Two, Three, Four and Five of this thesis.

Part One: Theoretical Framework

Part One: Theoretical Framework

Part One of this thesis provides an extensive exploration of New Zealand midwifery's professional project. I use the term 'professional project' as Freidson (1983) suggests, not to explore New Zealand midwifery through a generic notion of profession, but as an individual, empirical and historical case. Witz (1992) uses the term 'professional project' to establish the concrete and historically bound character of profession. Witz (1992) contends that the generic concept of profession is gendered but that working with an occupation as a 'professional project' opens the way to bringing female professions into view. Professional projects are strategies of occupational closure that seek to establish control over an area of work through the use of legalistic and credentialist tactics (Witz, 1992).

Part One comprises two chapters. The first begins this exploration by identifying why New Zealand midwifery needed to seek professional status. It then moves on to explore sociological theory of profession with emphasis on Abbott's (1988) model, 'system of professions' and Witz's (1992) model of occupational closure as two conceptual models through which New Zealand midwifery's professionalising strategies can be explored. The second chapter draws on this theory and presents an overview of New Zealand midwifery's professional project. The four integrated professionalising strategies used by New Zealand midwifery in its professional project are introduced. Each of these strategies is explored further through Parts Two, Three, Four and Five with reference to the theoretical framework presented in Part One.

Chapter One: Midwifery and professionalism

Introduction

This chapter focuses on professionalism as the integrating theme that runs through this professional doctorate. I begin by discussing why New Zealand midwifery sought to re-establish itself as a profession and then move on to discuss some of the existing literature on professions, professionalisation and professionalism. In particular I explore the work of Abbott (1998) and Witz (1992) whose respective models of 'systems of professions' and 'occupational closure' provide useful conceptual models through which to explore New Zealand midwifery's professional project.

I will move now to the background to professionalism, in which the reasons for New Zealand midwifery embarking on this professional project are explored.

Background to professionalism

Midwifery in New Zealand claims to be a profession and contends *"the midwife works in partnership with women, on her own professional responsibility..."* (New Zealand College of Midwives, 2005, p. 4). This claim to professional status is relatively recent for New Zealand midwifery and was part of midwifery's response to the threat we faced from total control by a related discipline, nursing, after the enactment of the 1971 Nurses Act. While midwifery has been a regulated workforce since 1904, successive changes to legislation from 1925 onwards, gradually combined midwifery with nursing, until in 1971 the Nurses Act removed the word 'midwife' from the title of the legislation altogether and defined a midwife as a nurse by stating that, *"'Nurse' or 'Registered Nurse' includes ... a registered midwife"* (Nurses Act 1971, Section 2). This Act also removed the right of midwives to practise independently by making it an offence to carry out *"obstetric nursing in any case where a medical practitioner has not undertaken responsibility for the care of the patient"* (Nurses Act 1971, Section 52 .1). Although there were only a few domiciliary midwives practising independently by 1971, this requirement for a medical practitioner to be

responsible for the care of all pregnant women brought to an end the right of midwives to limited autonomy in midwifery practice that had existed in law since 1904 (Donley, 1986).

Further restrictions and controls to midwifery practice were made through the 1983 Amendment to the Nurses Act 1977 when, amongst other things, direct entry trained midwives were denied the right to practise in the community as domiciliary midwives and Medical Officers of Health were given increased powers to suspend domiciliary midwives on suspicion of unhygienic practices (Donley, 1986). This focus on restricting domiciliary midwifery in particular reflected the maternity service context in the early 1980s in which consumer activists were demanding more family-centred maternity services and the medical specialty of obstetrics was attempting to establish its dominance within maternity services. Various strategies were used by obstetrics to counter the concerns of maternity consumers and to bring domiciliary midwives under the control of obstetricians. These included: influencing policy that attempted to make maternity hospitals so appealing that women would not choose homebirths; and establishing an all encompassing set of 'risk factors' to determine which women must be referred to obstetricians during pregnancy and birth (Board of Health, 1979, 1982; Bonham, 1983). Nurses and some midwives supported these strategies by developing policy that would set standards for domiciliary midwives and establish a monitoring role for nursing and obstetrics over domiciliary midwifery practice (NZNA, 1981; National Midwives Section cited in NZNA 1981).

Alongside the legislative loss of midwifery autonomy and these subsequent attempts to control domiciliary midwifery practice, midwives feared further erosion to their professional identity when midwifery education was downgraded. Hospital-based midwifery programmes were closed and replaced by specialist components within advanced nursing programmes located in tertiary educational organisations (Pairman, 2002). The new courses were inadequate for the preparation of midwives and led to a drastic decrease in the numbers of midwives training in New Zealand (Donley, 1986; NZNA, 1987).

It was a combination of these factors that persuaded hospital and domiciliary midwives to put aside their philosophical differences and unite in a political campaign to reclaim their identity as an occupation that was separate to nursing. Using the democratic processes of the professional organisation for nurses and midwives, the New Zealand Nurses Association (NZNA), midwives, through the National Midwives Section of NZNA succeeded in changing NZNA policy to support separate midwifery programmes and to accept the International Confederation of Midwives' Definition of a Midwife as a 'person' rather than a 'nurse' (NZNA, 1987; NZNA, 1989). Further detail about these political activities is provided in Part Four.

While midwives were actively working to reclaim their separate identity and improve midwifery education, maternity consumers were protesting about lack of control for women and families, increased medical and technological intervention, and lack of choice for women in the maternity services. They identified the threat to midwifery of inadequate education and lack of professional autonomy. Without well-educated and autonomous midwives, women feared they would have no chance of reclaiming birth as a natural process over which they had some control and could make their own decisions. Maternity consumer groups such as Parents Centre New Zealand, Home Birth Association, Save the Midwives, and the Direct Entry Midwifery Taskforce actively campaigned for changes to midwifery education that would produce a midwife capable of working within the full scope of midwifery practice and supporting women to have the birth experiences they sought (Strid, 1987; Dobbie, 1990; Kedgley, 1996). As the President of Parents Centre said in 1983:

> *The dying out of midwifery in New Zealand could change the face of obstetrics irrevocably. The rate of intervention in birth would soar. We too could have a 20% caesarian rate. We too could have routine scans, episiotomies, fetal monitors, inductions. We need midwives. Our babies need midwives. The doctors need midwives. The whole health system needs midwives.* (Thompson cited in Dobbie, 1990, p.126).

It was a certain type of midwife that women were seeking and many believed that the only way to achieve this was through re-establishing direct entry midwifery education, so that women could be educationally prepared for midwifery without first completing a nursing

qualification. As Judi Strid, Coordinator of Save the Midwives and the Direct Entry Midwifery Taskforce said;

> *We need to more actively promote the midwife as a positive presence who focuses on the childbearing woman and her baby with the knowledge and skill required, but with a sensitivity and respect for the individuality and uniqueness of each woman and her choices for birthing* (Strid, 1987, p.15).

Thus the objectives of midwives and women were complementary. Women wanted to regain control over their childbirth experiences and believed that midwives were the ones to help them. Midwives sought to regain their identity as midwives rather than nurses and control over their midwifery practice. In 1986 the Midwives Section formally joined with the Direct Entry Midwifery Taskforce to work towards direct entry midwifery education, and encouraged midwives to join local maternity consumer groups to raise awareness of the role midwives could play in achieving women-centred maternity services and to widen the consumer support base. This grouping of the Midwives Section and maternity consumer organisations developed a strategy for change. They agreed to work together to first achieve midwifery autonomy and improve midwifery education for nurses and then to work together for direct entry midwifery education.

The detail of this successful political campaign has been discussed elsewhere (Donley, 1989; Guilliland, 1989; Pairman, 1998a; Pairman and Guilliland, forthcoming) and it led to the enactment of the Nurses Amendment Act 1990. This legislation reinstated midwifery autonomy by requiring a doctor and/or a midwife to care for women during childbirth and it established a route for direct entry midwifery education through the provisions of the experimental programmes clause. It also provided a place for a midwife nominee from the newly formed New Zealand College of Midwives (NZCOM) on the Nursing Council of New Zealand (the regulatory authority for nurses and midwives until 2003), thus recognising NZCOM as the professional organisation representing midwifery. In order to make midwifery autonomy possible in practice a number of other pieces of legislation were amended. These changes included a role for NZCOM in negotiating the Maternity Benefit Schedule; admission rights to maternity facilities for midwives and their clients; rights to claim maternity benefits and pharmaceutical benefits and access laboratory diagnostic

services; and rights to prescribe drugs during pregnancy, birth and the postnatal period, including the controlled drug, Pethidine Hydrochloride.

Thus by 1990 midwifery had established its own professional organisation, the New Zealand College of Midwives, and gained a social mandate for autonomous midwifery practice through the 1990 Amendment to the Nurses Act 1977. This was a remarkable achievement in such a short space of time. However, the maternity service context for practice was still dominated by medical and institutional control. The majority of women gave birth in hospital under medical care and the majority of midwives were employed in maternity hospitals, working eight-hour shifts within hierarchical nursing structures and under medical supervision. What did the legislative right to midwifery autonomy mean to this workforce? How was midwifery going to shape itself into a profession with something unique to offer women and distinguish it from nursing and medicine? Before I explore these questions I will examine some of the definitions and theory of professions and how they work.

Professions, professionalisation and professionalism

In this section I will look specifically at what has been said about professions, professionalisation and professionalism. In so doing I will explore a variety of sociological literature to provide definitions of these terms and discuss various theoretical perspectives.

Definitions

There is an abundance of literature about professions: how they work, how they develop, what characteristics they have, and whether certain occupational groups can claim to be professions or not. Profession is a sociological concept that has been widely debated since the early 20th century and its evolution cannot be understood without reference to the socio-political context within which changes to the meaning of profession have occurred. A single definition of profession is difficult to find as definitions reflect varying perspectives on the essential elements, which are intrinsically tied to notions of professionalisation and professionalism. Freidson (1994, p.16) contends that the problem with definition is created by attempting to treat profession *"as if it were a generic rather than a changing historic*

concept, with particular roots in an industrialised nation strongly influenced by Anglo-American institutions. Nevertheless he does identify 'profession' as synonymous with 'occupation' on the basis that it refers to specialised work for which one is rewarded and gains a living. However, professions do a particular kind of work that is discretionary in nature, valued by society and requires theoretical knowledge and skill that ordinary people do not have (Freidson, 1994). Cruess, Cruess, & Johnston provide a summary of the characteristics of modern professions that then need to be considered separately in relation to professionalisation.

> *First, as professions hold specialised knowledge not easily understood by the average citizen, they are given monopoly over its use and are responsible for its teaching. Second, this knowledge is used in the service of individual patients and society in an altruistic fashion. Third, the inaccessible nature of the knowledge and the commitment to altruism are the justification for the profession's autonomy to establish and maintain standards of practice and self-regulation to assure quality. Fourth, professionals are responsible for the integrity of their knowledge base, its expansion through research, and for ensuring the highest standards for its use.* (Cruess, Cruess & Johnston, 2000, p.157)

Professionalisation is the process by which occupations become or seek to become recognised as professions, while professionalism involves internalisation of the profession's values and practices by its members. This includes commitment to the profession and its values as well as dedication to providing skilled and knowledgeable care (Jarvis, 1983). Professionalism develops through the required period of training to acquire knowledge and skill and the commitment to the profession's work becomes a central life-interest that provides its own intrinsic rewards (Freidson, 1994). Because professionals develop this commitment to the work and believe in its value to society, they are concerned with extending and refining it through research and continuing education (Jarvis, 1983, Freidson, 1994). In addition, a trusting relationship must exist between a professional and a client. Professional work is sufficiently complex as to make it difficult for clients to evaluate accurately and they must be able to trust the professional and expect to have that trust honoured. The client's needs must come above the professional's need to earn a living (Freidson, 1994).

Theoretical perspectives of profession and professionalisation

'Traditional' approaches

Nineteenth century notions of profession reflected the rigid social hierarchies of the Victorian era where the privileged classes could enter the medieval universities that created the professions of law, medicine and clergy (Abbott & Wallace, 1990). These three professions were labelled by Elliot as 'status professions' to distinguish them from 'occupational professions' that later developed (Elliot, 1972). While medicine, law and the clergy were considered high status professions; nursing, social work and teaching were labelled as semi-professions because their work was perceived to be more 'supervised' and 'applied' than the more autonomous work of the established professions (Etzioni, 1969; Abbott & Wallace, 1990; Hoyle, 2001). High status professions were identified as more difficult to enter, whereas lower status professions were more accessible (Etzioni, 1969). These status professions continue to provide a model against which other claims to professional status are measured, although their status is being challenged by a variety of social, political and economic influences that will be discussed later.

The 19th century professions were characterised by: monopolisation of specific expertise and knowledge; collegial organisation that also served to erect social boundaries and control entry to the profession through formal education and examination; and an ideology of public service and altruism expressed through enforced codes of behaviour (Abbott, 1988; Abbott & Wallace, 1990; Broadbent, Dietrich & Roberts, 1997). These concepts of profession were developed though a body of literature known as the taxonomic approach (Dietrich & Roberts, 1997), which asserts that professions are a special category of occupations that possess unique distinguishing attributes. A number of traits were identified including possession of specialised skills, requirement for intellectual and practical training and establishment of a professional body through which members accepted collective responsibility for maintaining the integrity of the profession (Dietrich & Roberts, 1997).

Within the taxonomic approach professionalisation was seen as a natural process or sequence in which occupations: establish training schools or specific programmes within universities; form a professional association to define the core tasks of the occupation and establish an area of exclusive competence; seek legal protection of the job territory and self-regulation through licensing and certification; publish a formal code of ethics; and both limit entrance to the profession and control the behaviour of members, whilst reassuring the public that the profession will serve its needs (Jarvis, 1983; Abbott, 1988).

A central criticism of this taxonomic view is that it provides description but not analysis and takes no account of inequalities in power distributions between professionals and consumers of professional services (Abbott, 1988; Dietrich & Roberts, 1997). Functionalist sociologists saw the relationship between the professions and society as an exchange: professional expertise was exchanged for autonomy, status and economic reward. Highly qualified and motivated people were attracted to professions in order to access these privileges and through their skills high standards of professional practice were maintained (Dietrich & Roberts, 1997).

The 'power' approach

From the 1960s this established concept of professionalisation was challenged and reshaped by sociologists working from a power approach (Abbott, 1988). Elliott Freidson, from his examination of medicine as a profession, asserted *"a profession is distinct from other occupations in that it has been given the right to control its own work* (Freidson, 1970, p.71). This technical autonomy, however, is not absolute and professions ultimately depend on the power of the state for protection. The privileged position of a profession is thus *"secured by the political and economic influence of the elite which sponsors it* (Freidson, 1970, p.73). Freidson (1986) argued that the cognitive and normative characteristics of a profession were important, not because they defined profession, but because they were used to persuade outside elite sponsors or political authorities to support a profession's claim to monopoly over certain aspects of the labour market. Thus no precise definition of profession can be made, because profession is merely a title claimed by certain occupations at certain points in time (Freidson, 1994).

Another theorist from the power paradigm was Terence Johnson. Johnson (1972) defined profession as a method of controlling work, whereby an occupation exercises control over its work rather than individuals or an agency mediating between occupation and consumer and he emphasised the power of the political process in establishing this control. Johnson, therefore, concentrated on the relationship between profession and state, which he saw as simultaneously hostile and interdependent.

The important distinction in the work of power theorists like Freidson (1970, 1986, 1994) and Johnson (1972) was that they emphasised the ideologic nature of professional claims, their unjustified privilege and monopoly and the way that authority is created and exercised over clients. Ideology is inherent in the status of profession because cognitive and normative elements are used ideologically in the struggle to achieve professional status, and once reached, this position allows the profession to define and construct particular areas of social reality on the basis of the conferred validity of their expertise (Larson, 1977). Indeed a profession is entitled to define the standards by which its superior competence is judged. Larson contends that professional autonomy insulates professions and that they live within *"ideologies of their own creating, which they present to the outside as the most valid definitions of specific spheres of social reality"* (Larson, 1977, p.xiii). This ideology justifies inequality of status and social closure between occupations.

Most work within the power approach is classified as either Marxist or neo-Weberian (Dietrich & Roberts, 1997). The Marxist analysis of profession is centred on the social relations of production and the class system. The professions can be seen as sharing characteristics with both the exploited and the exploiters as they try to use their professional power to gain entry to the exploiting class (ibid). This elitism was seen by critics to reinforce the class system and its exclusionary 'social closures' to limit opportunity (Freidson, 1994). The neo-Weberian analysis of profession focuses on market conditions whereby society provides an arena for competition between occupations and between occupations and the state, to gain power and status. The focus on how professional markets are constituted leads to comparison of the marketability of professions' specific cognitive

resources. In other words how they translate the scare resource of specific expertise into social and economic rewards.

Magali Larson (1977) drew on both Marxist and neo-Weberian perspectives in her theory of the historic process of professionalisation. She identified two phases of modern professionalisation. The first was a historically specific phase that coincided with industrialisation and laissez-faire capitalism and in which the model of profession first arose. The second phase involved the replacement of the model of profession with the ideology of professionalism (Larson, 1977). Larson contends that an occupation requires a body of relatively abstract knowledge with practical application and a market or potential market for the occupation's services. She uses the concept of 'professional project' to identify the concrete and historically bounded character of profession. In Larson's analysis profession is treated as a historically specific project that attempts to secure structural linkage between a profession and its knowledge base and between knowledge and power (Larson, 1977).

Market competition determines the centrality of education in the structure of modern professions so that professions can claim an exclusive body of knowledge with which to gain market monopoly. However, outsiders often produce new knowledge and there is a risk that a profession's knowledge base can evolve independently of the profession itself unless *the production of knowledge and the production of producers are unified into the same structure* (Larson, 1977, p.17). Therefore professions need to establish cognitive exclusiveness by ensuring control over how new knowledge is to be applied. Larson contends that the negotiation of this cognitive exclusiveness, so essential to professional monopoly, is secured in the empirical arena of the modern university. Thus a profession forms interdependent relationships with universities in relation to its body of knowledge; thereby developing an autonomous means of closure, by controlling access to education and knowledge. Then the scarce resource of specific bodies of technical-theoretical knowledge could be used to create a professional market that brought social and economic rewards to the profession. Autonomous means of professionalisation are those created by professional groups themselves. Heteronomous means of professionalisation are those that

are mainly defined or formed though other social groups, such as registration and licensing that are institutionally located in the state (Larson, 1977).

Larson's work on 'professional project' and her definitions of autonomous and heteronomous means of professionalisation is relevant to the discussion of New Zealand midwifery's professionalising strategies in this thesis and I will return to it later.

Thus far I have looked at two main perspectives of profession. The first was the 'trait' approach whereby theorists attempted to identify the characteristics of 'true' profession and provide the 'ideal' against which claims to professional status can be measured. This approach to profession has been critiqued for its emphasis on function and structure and for its uncritical acceptance of professional self-definition. Its descriptive approach provides no basis for analysis (Dietrich & Roberts, 1997). The second perspective was the 'critical' approach where theorising moved way from a profession's role in holding society together, to focus on issues of power and competition. Freidson (1970, 1986, 1994, 2001) and Larson (1977) in particular, provided analyses of how professions used ideology as a means to professional power, how professional authority and monopoly depended on support from the state or some powerful elite and how professions competed for market monopoly on the basis of an exclusive knowledge base.

Both perspectives are useful to the examination of midwifery professionalism in New Zealand. I will make the case that New Zealand midwifery deliberately set out to gain professional autonomy in order to challenge the dominance of medical ideology in childbirth and to compete with doctors over an area of work. It sought state support for its case on the basis of expertise in normal childbirth and it strengthened its case politically by gaining public support from women and defining its case as a women's health issue. I will also draw on the work of Abbott (1988) who identified a 'system of profession' and Witz (1992) who provides a central critique of profession on the basis of gender. I will move on to discuss their work.

The 'system of professions'

Abbott's analysis of the role of jurisdictional claims and disputes in competition between professions took the sociology of profession in a new direction (Freidson, 1994). Abbott proposed an alternative theory of professionalisation that shifts the focus from structure and power to the content of the profession's work (Abbott, 1988). He argues that the content of the professions work is changing; that control of work brings the professions into conflict with each other, leading to interdependence; and that differentiation in types of work leads to differentiation within the profession. For Abbott, the central phenomenon of professional life is the link between a profession and its work, that he calls jurisdiction. Abbott's theory of professionalisation analyses how jurisdiction is created, how it is anchored by formal and informal social structures, and how the interplay of jurisdictional links between professions determines their history and development (ibid).

Professions have social mandates for jurisdiction over a certain set of tasks. It is the philosophical position from which a profession approaches its tasks and the way in which it enacts these tasks that reflects the culture of a profession and distinguishes it from another. Professional tasks are human problems that can be assessed and assisted by expert service. Tasks are also culturally and socially defined and therefore the degree to which experts deal with these problems varies from society to society and through history. For example, family members, women in the community with certain experience, man-midwives, trained midwives, general practitioners, and obstetricians, have variously managed the natural life event of childbirth in western societies.

Abbott contends that tasks have both subjective and objective properties and that these are important to understand when examining how professions compete for jurisdiction over tasks. The opposition of objective and subjective does not relate to natural or technological and mental, but rather relates to properties that are moveable or fixed (Abbott, 1988). Objective sources of tasks include technology and organisations, on which, for example, information technology professions or teaching respectively are based. The body and the physiological process of childbirth is an objective aspect of the work of midwives and of obstetricians. A profession is vulnerable to changes in the objective character of its central

tasks. In the case of New Zealand midwifery, medicine's definition of physiology as 'only normal in retrospect' eventually resulted in medicine taking control of normal (physiological) childbirth away from midwives. A task also has subjective qualities that make it vulnerable to change. The profession that holds jurisdiction over them constructs the subjective qualities of a task. It does this through the process of diagnosis, inference and treatment, which are the actions of professional practice. The construction of the tasks strengthens the profession's ties to the task. According to Abbott (1988) it is both the objective and subjective qualities of tasks and of work with them that determines how vulnerable the tasks are to competition from other professions. Academic development of professional knowledge also allows a profession to make claims of jurisdiction over new areas, but these claims remain only theoretical unless a profession can succeed in gaining public support and legitimation.

Claims of jurisdiction can be made in the legal system, in the arena of public information (media) or in workplaces and success may lead to monopoly over practice and public payments, rights of self-discipline, unconstrained employment, and control of professional training, recruitment and licensing (Abbott, 1988). In addition to full jurisdiction there are other forms of settlements that can take place as a result of competing professional claims. Settlements may include: subordination of one profession under another; division of the tasks or sharing of the tasks; advisory control by one profession over aspects of the work; and division of jurisdiction according to the nature of the client (ibid). The last is a workplace settlement and often occurs in large professions where differentiation occurs within the profession. For example nursing has jurisdiction over nursing care but in some settings nurses retain control over certain complex tasks and delegate less complex tasks to second level nurses. This division of labour can be made on the basis of the client, where for example, nurses care for those in hospitals with complex needs and second level nurses care for the elderly in long-term care facilities.

In summary Abbott states (1988, p. 84):

> *The central organising reality of professional life is control of tasks. The tasks themselves are defined in the profession's cultural work. Control over them is established ... by competitive claims in public media, in legal discourse, and in*

> *workplace negotiation. A variety of settlements, none of them permanent, but some more precarious then others, create temporary stabilities in this process of competition. Those settlements reflect in some ways the social structures of the professions involved, but also depend on the many variables making for strength and weakness of jurisdiction.*

Abbott contends that professions are never seen alone and cannot be defined by a single encompassing category of 'the professions'. They exist in an interdependent system of professions. Because cultural and social control over work leads to exclusive jurisdiction, a move by one profession inevitably affects others. While jurisdiction is not as exclusive a property as dominance, it is still true that one profession's jurisdiction pre-empts another's. Professions compete within this interacting system, and a profession's success reflects not only the profession's own efforts but also the situation of its competitors and the system's structure. Chains of effects in the system of professions can begin externally through new opportunities for jurisdiction or though closure of a jurisdiction, or internally through new or existing professions seeking new areas of control. The chains of effects will lead either to professionalisation or deprofessionalisation of some groups, and jurisdictional claims occur at every link in the chain.

In summary, Abbott's systems model postulates that the essence of a profession is its work not its organisation; that many variables affect the content and control of that work; and that professions exist in an interrelated system.

This system model is useful for examination of New Zealand midwifery's professionalising strategies. The relationship between midwifery, medicine and nursing in New Zealand can be examined with an eye to their interdependence. Changes in medicine impacted on both midwifery and nursing in the early part of the 20th century when medicine assumed control over childbirth. Midwifery was subordinate to nursing in terms of its professional identity and this was partly the impetus for midwifery to contest the jurisdiction of normal childbirth with medicine. The outcome of that successful claim has, in turn, had far reaching effects on a division of medicine known as general practice.

This systems model also shows that the internal structure of profession is only one of several determinants in jurisdictional contests and it recognises the impact of external social forces. Finally it recognises the inherent instability of jurisdiction and the impact that changes in tasks can have on professions in relationship to each other.

As will be discussed later, women's public support for midwifery was an external factor that strongly influenced the success of midwifery's claim for jurisdiction over normal childbirth. However, midwifery has continually faced challenges from medicine as it attempts to claim back the work of normal childbirth.

While Abbot's 'system of professions' provides a useful framework for exploring the development of midwifery as a profession in New Zealand it does not explore the relationship between gender and professionalisation, which is also of relevance for midwifery as a women-dominated profession.

Gender and professionalisation

As mentioned above some theorists have identified women dominant professions as 'semi-professions' on the basis that they are often located within bureaucratic organisations such as hospitals and that their work is 'supervised' and less autonomous (Etzioni, 1964). Women are deemed to be unable to act like men in relation to rationality, autonomy, exercising authority and collegiality and therefore they have a subordinate role to men, which is reflected in the notion of 'semi-profession' (Etzioni, 1964). Etzioni stated:

> *Part of the problem is due to the fact that the typical professional is a male whereas the typical semi-professional is a female. Despite the effects of emancipation, women on average are more amendable to administrative control than men. It seems that on average, women are less conscious of organisational status and more submissive in this context than men* (Etzioni, 1964, p.89).

This approach has been critiqued on the basis that it assumes the gender of the practitioner as a 'given' and applies supposed gender-specific attributes to women based on taken-for-granted sex-role theory (Abbott & Wallace, 1990; Witz, 1992; Davies, 1995a, 1996).

Anne Witz is one of the first to explore profession and power in relation to feminist ideas about patriarchy and gender. While her later work (Savage & Witz, 1992; Halford, Savage & Witz, 1997; Witz & Marshall, 2004) focuses on gender and organisations and feminist critique of sociology, her 1992 book 'Professions and Patriarchy' provides an important analysis of the relation between professionalisation and gender (Witz, 1992). Additionally Witz has drawn on sociological theories of 'dual systems' in order to develop a conceptual framework for the analysis of gender and the closure strategies adopted by professionalising occupations. Witz (1992) identifies the gendered dimensions of closure practices in professionalising occupations as exclusionary, inclusionary, demarcationary and dual closure strategies. I will draw on this framework in my exploration of New Zealand midwifery's professionalising strategies.

Witz (1992) contends that analysis of gender in professionalisation needs to be located within the concept of patriarchy as a societal-wide system of social relations of male dominance and female subordination. The patriarchal structuring of gender relations arises from the ways in which male power is institutionalised in various sites of social relations. Patriarchal gender relations are systemic in that they pervade social relations and social interactions and as they provide men with more privilege and advantage they are mutually reinforcing. The way that men dominate varies over time as a result of historic and cultural construction of male power. Nevertheless, patriarchy remains central in shaping workplaces.

Witz (1992) identifies three forms of patriarchal control over female labour. First, an *inclusionary* form, based on the notion of family, where the labour of women and children is under the control of the male head of the household. This mode of control operates by way of inclusion of women within patriarchal authority under the direct control of the husband (father). This form of control began to break down as women entered the labour market as individual wage earners and led to the second, *exclusionary* form of control. Exclusionary control occurs where male workers organise collectively to engage in attempts to prevent women entering certain male spheres of employment. The third form of control, a *segregationary* form, developed as more women entered areas previously

dominated by men, such as clerical work. The segregationary strategy began by segregating women into ancillary and less skilled tasks while at the same time excluding them from skilled tasks. It has evolved to a mode of control where male and female occupations are demarcated according to gender, thus creating a hierarchical and gendered order of occupations.

Davies (1996) argues that contemporary understanding of gender and profession focuses not so much on the exclusion of women, but on the particular way they are included. Gender is seen as *"one cultural resource among many, called upon in the process of creating and sustaining identities, utilised in daily interaction, available as image and metaphor in the shaping of organisational and institutional arrangements"* (Davies, 1996, p.665).

Witz (1992) notes that gender has also provided a resource for solidarity and collective action, not only for men, but also for women. This is an important point for New Zealand midwifery as the profession has located its identity in relationships between women and articulated a philosophy that is women-centred. New Zealand midwifery has used gender to strengthen its claim to professional autonomy.

Examination of profession through the lens of gender relations shows that notions of masculinity and femininity are embedded and constitute social relations. Masculine values lead to organisation of work that is controlling and controlled through interpersonal relations that are distant and emotionally detached. Those values culturally assigned to women are trivialised and women's support work is unacknowledged (Davies, 1996). Using nursing as a case study, Davies contends that women are overtly excluded from areas of work and reward through patriarchy, but that this understanding also requires recognition that the system of gender relations already includes women and in fact does not work without this inclusion. This inclusion is hidden and denied. Davies (1996, p.673) argues that,

> *Whenever women occupy a place in the public world that is predicated on the exclusion/inclusion problematic, on the central denial of the significance of the Other that is involved in binary gendered thought, that place will be a profoundly*

uneasy one, inexplicable and unresolvable unless the exclusion/inclusion problematic is more formally and more fully understood.

Anne Witz's (1990, 1992) model of exclusionary and demarcationary strategies on the part of dominant and subordinate groups provides an analysis of gendered dimensions of closure practices in professionalising occupations and recognises that women as well as men engage in professional projects. Witz (1990) identified exclusionary, inclusionary, demarcationary and dual closure strategies as gendered strategies of occupational closure.

Inclusionary and dual closure strategies are the counter responses of groups (usually women) who are subject to exclusionary or demarcationary strategies. Inclusionary strategies are used in response to exclusionary tactics. Dual closure strategies are responses to demarcationary tactics.

Exclusionary strategies are internal mechanisms used by occupations to control entry to the occupation and create a monopoly over knowledge and skills. Gendered forms of exclusionary strategy are those exercised by a dominant social collectivity, men, and which define women as 'ineligible' on the basis of gender. They secure privileged access to rewards and opportunities for men through excluding women from routes of access to resources such as qualifications and technical competence (Witz, 1990, 1992). These strategies use gendered collectivist criteria of exclusion in relation to women but gendered individualistic criteria of inclusion in relation to men. Frequently exclusionary mechanisms are embedded in institutions in society such as universities where male power is institutionalised so they are only indirectly reinforced within the institution of the state. Thus women have generally been excluded from, for example, medicine, through restriction of access to education or accreditation rather than by legislation (Witz, 1990).

Inclusionary strategies are responses to exclusionary tactics and relate to those whereby the excluded group women do not acquiesce in the face of patriarchal closure but seek inclusion within the structure from which they are barred through challenging the male monopoly over competence (Witz, 1990). Inclusionary strategies are usurpationary in that they are countervailing strategies, in tension with exclusionary strategies. Inclusionary

usurpation strategies can also be seen as revolutionary if they are a direct attempt to change the structure of positions (Witz, 1990).

Demarcationary strategies are attempts by occupations to mould the division of labour to their own advantage. Dominant social or occupational groups who have greater access to power resources than those they seek to control use demarcation strategies. Gendered strategies of demarcationary closure involve the creation and control of boundaries. They relate to processes of inter-occupational control rather than to processes of intra-occupational control (Witz, 1990). Rather than excluding women, they are included, but in a subordinated role with a distinct scope of competence in the division of labour (Witz, 1992).

Dual closure strategies are the countervailing response of groups hit by the demarcationary strategies of dominant groups. Dual closure strategies take a simultaneous two-pronged approach. First they resist the demarcationary strategies of the dominant group in an upward countervailing exercise of power. Second, they consolidate their own position within the division of labour by employing their own exclusionary strategies. Therefore dual closure strategies involve the use of both usurpationary and exclusionary activities. There is a simultaneous two-way exercise of power upwards (usurpationary) and downwards (exclusionary).

Witz (1992) has used midwifery in the United Kingdom in the 19th century as a case study of a 'female professional project' that used dual closure strategies as responses to the demarcationary strategies employed by medicine. Whilst this is an analysis of 19th century midwifery in Britain its relevance to midwifery in contemporary New Zealand will become evident.

Medicine as a profession was resistant to British midwifery's attempts to gain registration, but two groups within medicine used two different demarcationary strategies to respond to midwifery's aim. General practitioners sought to abolish female midwifery as a distinct occupational role and *incorporate* midwifery skills into the exclusive domain of doctors.

Obstetricians, on the other hand, sought to preserve independent midwifery, but used a *deskilling* strategy to ensure a rigidly restricted scope of practice and de-skilled sphere of competence for midwives (Witz, 1992).

The incorporation strategy opposed midwifery registration and aimed to replace midwives with the dependent role of 'obstetric nurse' who would work under the supervision and control of the doctor. The de-skilling strategy, on the other hand, devolved attendance on normal labour to the midwife while giving exclusive prerogative over abnormal labour to the obstetricians.

While advocates of the de-skilling strategy supported midwifery registration they sought to control the occupational infrastructure of midwifery so that they could control the education and registration processes. General practitioners opposed the de-skilling strategy because they feared competition by midwives would threaten their income and their monopoly. However, the de-skilling strategy eventually prevailed because doctors alone could not meet the demand for midwifery services and many did not want to work the hours that would be required to do this (Witz, 1992).

Midwives responded with professional projects that involved dual closure strategies. There were two main groups of midwives. The first, the Female Medical Society, active in the 1860s and early 1870s sought to secure autonomy of midwives from doctors and resisted professional subordination of midwifery to the medical profession through a revolutionary dual closure strategy. These midwives defined a broad scope of practice for midwifery that included normal and abnormal childbirth and the use of instruments, and sought midwifery registration that gave midwives separate but equal professional status with doctors (Witz, 1992).

Midwives established their own professional association as well as an extensive education programme that included not only skills with instruments, but also obstetrical operations. It was envisaged that the registration process would establish midwifery as a separate but related specialty of medicine and that midwives would supersede doctors in maternity care

because of their enlarged scope of practice. The society eventually closed through lack of funds and once women were admitted to full medical education in the 1870s, this took priority over securing a partial education in the specialty of midwifery (ibid). However, the arguments were still submitted to the 1892 Select Committee on Midwives Registration.

The second group, the Midwives Institute, founded in 1882, pursued a more accommodative dual closure strategy that accepted a limited definition of scope of practice to normal birth and a system of registration that gave control over midwifery education, examination and registration to medicine (Witz, 1992). The rationale for pursuing this accommodative strategy of dual closure was that it preserved midwifery autonomy within the defined scope of practice, and that doctors would not supervise midwives' daily work.

The Midwives Institute put more energy into seeking heteronomous means of closure by a state-sponsored system of midwifery registration than they did in arguing for an extended scope of practice because they believed that parliamentary recognition of midwives would raise the status of midwifery and therefore attract women from the 'educated classes' into midwifery. Because of the historical context in which this took place, the dominant male profession of medicine necessarily mediated the state-profession relation of midwives. This meant that when the Midwives Act was eventually achieved in 1902 it was mainly doctors who were appointed to the regulatory body, the Central Midwives Board, thus effectively giving control of midwifery education and registration to medicine (Witz, 1992).

Witz's (1992) conceptual model of the gendered dimensions of occupational closure will be used, along with Abbott's 'system of professions' as a framework within which to explore New Zealand midwifery's professional project. In particular, each of the four integrated professionalising strategies will be discussed in relation to these frameworks to determine whether they can add to our understandings of how the strategies employed by New Zealand midwives have worked and how they make be challenged in the future.

I will move now to examine some critiques of profession. These relate to the self-interest of professions; the disabling and disempowering impact of professions on individuals and

societies; reasons for decline in professions and ways that professions have responded; and the potential for 'new' professionalism.

Critiques of profession

Other than critique of professions for their patriarchal structures, there has been a substantial critique from other perspectives. The main body of work critiquing profession began in the 1960s. Historians and sociologists began to criticise professions for their economic self-interest and concern for status, and analysed how they controlled the poor and disadvantaged in society through their professional activities (Freidson, 1994).

In 1977 Illich, Zola, McKnight, Caplan & Shaiken in their book 'Disabling Professions' criticise the power of professions and argue that society's dependence on professions is both disabling and disempowering. Professions claim the right to diagnose problems, decide how to manage the problem and decide whether the management is appropriate. As a result individuals and society become more dependent on professions and the resultant disabling ideology *"converts citizens to clients, communities to deficient individuals and politics to a self-serving debate by professionals over which service system should have a greater share of the Gross National Product* (McKnight in Illich et.al, 1977, p.90). Thus the existence of experts discourages people from learning how to do things for themselves and from relying on themselves and their communities.

The Boston Women's Health Collective provides a good example of this disabling effect on women. The Collective was formed as a result of women's anger at their lack of knowledge and lack of control in the medical system (Phillips & Rakusen, 1970). In line with the political agenda of the wider international women's health movement, the Collective challenged medical power through accessing and sharing information from other sources to equip women to take more control of their lives.

Feminist writers, Ehrenreich and English, challenge the assumption that professions actually offer expertise and they criticise professions for their exclusionary processes at the levels of gender, ethnicity and class. They say:

> *We must never confuse professionalism with expertise. Expertise is something to work for and to share: Professionalism is - by definition – elitist and exclusive, sexist, racist and classist* (Ehrenreich & English, 1973, p.42).

Debates between the power theorists themselves centred on whether professions were based on Marx's concept of class or Weber's ideal type of bureaucracy (Burrage, 1990) and professions were criticised on the basis that they represented unjustified elitism that reinforces the class system (Freidson, 1994). Medicine was a prime target for criticism throughout the 1970s because it was seen to dominate social policy, other health occupations, the institutions in which it worked, patients or consumers and for how it has 'medicalised' life (Freidson, 1994). European sociologists criticised Anglo-American sociologists for their insular and ethnocentric interpretations of profession and sought to distinguish different paths for professions within different cultural and political contexts (Burrage, 1990; Hoyle, 2001; Freidson, 1994).

Later in the century there has been a general shift to predicting the decline of medicine and other professions because of the consequences of a number of socio-political processes such as privatisation, corporatisation, managerialism, and consumer movements, as well as internal shifts in profession themselves such as specialisations (Freidson, 1994).

The central criticism of professionalisation is that it is project for self-interest of the profession at the expense of client interests (Hoyle, 2001). Critiques of the autonomy of professions suggest that professions' protection of their autonomy lead to: barriers between professionals and their clients; avoidance of legitimate accountability to a variety of stakeholders, including the state; and creates a barrier to increasing professionalism (Hoyle, 2001).

Concomitantly shifts in social relations within post modern cultures have replaced 19th and 20th century grand theories about the importance of hierarchical structures for the promotion of common good with a philosophy of individualism (Colyer, 2004). This philosophy privileges personal autonomy, empowerment and subjectivity. Within the health professions this means that the dominant medical model of health is being challenged by

social models of health with a greater emphasis on both alternative sources of knowledge and ways of seeing the world and non-medical aspects of care that improve individual experiences of clients (Katz Rothman, 1991; Colyer, 2004; Downe & McCourt. 2004).

The new language constructs patients as consumers of health care and health is seen as a commodity, rather than a public service in which professionals act ethically in the interests of patients (Colyer, 2004). Linked with this is the notion of 'choice' and the rights of individuals to make their own decisions. While it is not in the scope of this thesis to critique the concept of 'consumer', this is a term that New Zealand midwives and maternity activists have deliberately chosen to use, at times, in relation to the women who use midwifery services. This is because it implies a shift in power when individuals can choose services from professionals with an expectation that the service will meet their needs. At the same time, if the individual is not satisfied with the service then they are free to seek services elsewhere. This shift in social relations has impacted on the process of deprofessionalisation.

Deprofessionalisation, proletarianisation and 'new professionalism'

As a result of the challenges and critiques to the monopoly of professions since the 1970s there has been a growing argument that professions are losing their power. Freidson (1994) identified two main arguments, the deprofessionalisation thesis and the proletarianisation thesis.

The deprofessionalisation thesis suggests that professions are losing their position of prestige and trust (Haug, 1975). This is evidenced by the gradual disappearance of several characteristics of professions such as the erosion of professional monopoly over knowledge, the questioning of professional autonomy and authority, and challenges to professional status. As a result the special prestige and authority enjoyed by professions is eroding, professionals are no longer protected from negotiation and compromise with clients and jurisdictional monopoly over work and tasks is being lost (Haug, 1975).

Threats to knowledge monopoly stem from information technology and increased public access to information, increasing levels of education, and increasing specialisation in the division of labour (Freidson, 1994). Threats to expertise also arise from the increase in consumer self-help groups such as the Boston Women's Health Collective mentioned above, whose extensive experiential knowledge can be claimed to rival the professional's. The effect of these challenges to professional monopoly changes public opinion and leads to loss of trust and prestige. This in turn leads to demand for greater accountability and the protection of client's rights. Taken to its logical conclusion, if professionals can only offer information with the client in a position to seek alternatives, the concept of profession will be obsolete and replaced by a consumer model (Haug, 1975; Freidson, 1994). As will be discussed later New Zealand midwifery has used elements of this deprofessionalisation thesis to support their case for women's choice in childbirth. However, midwifery has had to show that it offers women more than just information, and thus our professional expertise has been constructed around partnership.

The proletarianisation thesis emphasises what happens to professional work in large organisations. This thesis stems from Marx's assertion that over time capitalism will reduce nearly all workers to the status of the proletariat. In other words, workers will be dependent on selling labour with no control over their work (Freidson, 1994). Employment rather than self-employment is the common denominator of proletarian status. Employment implies loss of control over work through the bureaucracy of large organisations. The long-term trend for professionals is to be employed rather than self-employed, although Freidson argues that the norm for professionals has always been employment (Freidson, 1994). He further argues that employment does not necessarily mean lack of control over work. However, when the organisations employing professionals are integrated into large public or private systems of bureaucracy, such as hospitals, there may be conflict between bureaucratic administration and professionalism. Tension exists between professional's allegiance to their profession and their wish to control their work in light of their own standards, and bureaucratic administrators who privilege organisational requirements over those of professions. Calnan and Williams (1995, p.220) have identified proletarianisation as involving,

> *Occupations becoming more subordinate to the requirements of production, and more concretely it involves an increased emphasis on managerial imperatives (productivity, cost efficiency) and greater specialisation/deskilling with other health care workers.*

Barnett, Barnett & Kearns (1998) identify the rise of managerialism, deregulation of health care markets and corporate restructuring as key influences on the proletarianisation process in health care. They use the example of the reinstatement of midwifery autonomy in New Zealand in 1990 as an example of new health providers who have emerged with the assistance of deregulation, to challenge medical control over childbirth through deskilling (Barnett, Barnett & Kearns, 1998).

Parkin (1995) draws from both deprofessionalisation and proletarianisation theses in proposing four reasons for the gradual decline in power of health professions. Firstly, bureaucratic systems of governance introduced to promote standards, maximise effectiveness, assure quality and manage risk have become institutionalised within the organisational structure of health services (Freidson, 1994; Parkin, 1995; Perkin, 1996; Colyer, 2004). This has had the effect of undermining professional autonomy through mechanisms such as best practice clinical guidelines and protocols that aim to manage care through standardized and evidence-based care pathways (Colyer, 2004; Timmermans & Kolker, 2004).

Secondly, the gap between knowledge and competence of professional as 'expert' and the public has narrowed as a result of increased education and increased access to consumer information (Parkin, 1995; Pawlson & O'Kane, 2002). This has lead to challenges to professional knowledge and expertise and reduction in the public's belief in the service ethos and goodwill of professions, alongside increased demand for patient's rights' and ideologies of partnership and participation (Parkin, 1995).

Third, there are continual shifts in the control of work as occupations encroach and claim territory from others and formulate new divisions of labour (Parkin, 1995; Colyer, 2004). Care pathways and standardisation of tasks have provided other health workers with

opportunities to assume new roles or to replace professional care with cheaper, unqualified care (Parkin, 1995; Colyer, 2004).

Finally, the context of new right politics has impacted on all professions through the use of managerial models to curb professional power and impose market practices. Increasingly health professions are managed and controlled by complex industries and institutions such as insurance companies and health maintenance organisations that erode professional autonomy (Parkin, 1995; Sullivan & Benner, 2005). Managerialism has altered the culture of health care such that managers have the power and mandate to redefine professional roles and create new divisions of labour on the basis of competition and cost-effectiveness (Parkin, 1995, Perkin, 1996).

In responding to processes of deprofessionalisation and proletarianisation some professions have attempted to reverse concern with professional status and promote instead a 'new' professionalism framework which recognises the knowledge and experience of the client as well as the professional (Parkin, 1995; Tully, 1999; Hoyle, 2001; Pawlson & O'Kane, 2002). In this framework: professional/client relationships are more equitable and recognise the autonomy of both; professional knowledge and expertise is not privileged and information is shared with clients; professionalism emphasises quality improvement and performance measurement rather than an assumption of quality based on professional expertise; health care is rehumanised through relationships that build trust and in which professionals take on a more supportive and empowering role for clients (Parkin, 1995; Tully, 1999; Hoyle, 2001; Pawlson & O'Kane, 2002).

Medicine is one profession that has responded to deprofessionalisation through promoting a 'new' professionalism framework (White, 2004). A recent review of New Zealand's medical workforce identified increasing support for a 'new professionalism'. This report differentiated the characteristics of 'old and 'new' professionalism as: mastery of knowledge versus reflective practice; unilateral decision processes (patients as dependents, colleagues as differential) versus inter-dependent decision processes (patient empowered, colleagues engaged as equals); autonomy and self-management versus supported practice-

team work; individual accountability versus collective learning, responsibility and accountability; and detachment versus engagement (Health Workforce Advisory Committee, 2005).

However, Coburn, Rappolt and Bourgeault (1997) take a more sceptical view of the influence of these strategies in halting the decline of professional power. Using medicine in Ontario, Canada, as a case study, they argue that while a lesser degree of professional power is preserved through making minimal concessions, medical institutions are being co-opted by external forces, such as the state, into constraining their own members.

New Zealand midwifery provides an example of 'new professionalism' through its definition of itself as working 'in partnership' with women whereby knowledge about the body is constructed as an outcome of the relationship between a midwife and a woman (Tully, 1999; Lane, 2002; Page, 2003). Midwifery's claim of professional autonomy succeeded partly because the socio-political context of the 1980s lent weight to our case. The women's rights and patient's rights agenda challenged medical dominance and opened the way for social support for an alternative practitioner in childbirth services. State deregulation of health care also supported midwifery's claim, as midwifery could provide the necessary competition to doctors that would lessen their economic bargaining power over the state. Thus midwifery still sought professional power in order to exercise control over itself and its work, but we have used notions of 'new' professionalism to construct our professional identity and practice 'in partnership' with women.

Conclusion

This chapter has explored notions of profession, professionalisation and professionalism so as to develop a theoretical framework for the examination of New Zealand midwifery's professional project that begins in the next chapter. A number of concepts will be drawn through to this examination.

Midwifery sought the power of professional status in order to regain its identity as separate to nursing and to provide women with an alternative service to medicine in the provision of maternity care. However, even while seeking this professional status midwives and women were cognisant of the risks in taking on some of the characteristics of profession. In particular, notions of exclusivity, expertise and power 'over' clients were not congruent with midwifery's beginning understandings of itself in relation to women (clients). Midwifery sought to establish a new model of profession whereby midwives worked 'in partnership' with women, but still retained control of the profession through both autonomous and heteronomous means.

Witz's notion of 'professional project' provides a way to explore New Zealand midwifery as an individual, empirical, historical and gendered case. Abbott's (1988) model, 'system of professions' and Witz's (1992) model of 'occupational closure' provide two conceptual models through which New Zealand midwifery's professionalising strategies can be explored. Finally, the notion of 'new professionalism' provides a framework for New Zealand midwifery, as a profession 'in partnership' with women.

These theoretical understandings will be discussed further in Chapter Two and in Parts Two, Three, Four, and Five of this thesis. Part Six draws on these theoretical understandings in its concluding discussion of New Zealand midwifery's professional project.

Chapter Two: New Zealand midwifery's professional project

Introduction

This chapter explores New Zealand midwifery's professional project. I begin by discussing the professional structure of midwifery in the early part of the 20th century and show how midwives could exercise limited professional autonomy in their practice. I then consider how midwifery lost this limited autonomy to become a workforce that was dominated by both the professions of nursing and medicine. The main section of this chapter explores how New Zealand midwifery set about re-establishing itself as a profession through defining its professional identity as partnership, establishing its own professional organisation and achieving legislative change that reinstated midwifery autonomy. I conclude this chapter by identifying four key professionalising strategies that were used by midwifery to shift members from an employed workforce to a profession. Each of these strategies will be further developed in Parts Two, Three, Four and Five of this thesis.

In this chapter I will make the case for New Zealand midwifery as an example of 'new professionalism' whereby both the midwife (professional) and the woman (client) have recognised expertise and work together in reciprocal and equitable relationships (Davies, 1995a; Tully, 1999; Health Workforce Advisory Committee, 2005). By redefining traditional notions of professionalism New Zealand midwifery has established itself as a profession that recognises its primary commitment is to the women it attends and consciously works to put control over childbirth into the hands of women (Donley, 1989; Guilliland, 1989).

When talking about the New Zealand midwifery profession and the New Zealand College of Midwives as the professional organisation I use personal pronouns to indicate not only my leadership role within the profession, but also my identity as part of this profession.

Whilst it may appear artificial at times, it also felt inappropriate to speak of the profession in the third person.

I begin now by discussing the professional structures of midwives practising in New Zealand in the early part of the 20th century.

Early professional structures

New Zealand midwifery at the beginning of the 20th century did meet some of the early criterion-based definitions of professions such as: an identified area of expertise, individual and group autonomy within this area, a specialised training programme, limited entry, personal accountability for professional judgements and an emphasis on altruistic service. However, they were not self-governing, nor, at that time did midwives have access to extensive education programmes through which they could develop a specific body of knowledge. There do not appear to be any written codes of ethics and conduct for either midwifery or nursing at that time although there was an expectation that midwives should conduct themselves 'professionally' and be 'well presented' (Lambie, 1956).

Nevertheless it seems likely that midwives had a specific body of knowledge but it was articulated orally rather than written, because midwifery along with many other 'women's occupations, was beginning professionalisation from a history of exclusion from education on the basis of gender (Donnison, 1977). Nicky Leap and Billie Hunter's book, "The Midwife's Tale' records interviews with a group of British midwives who practised in the early part of the 20th century and experienced midwifery professionalisation in the shift from handywoman to professional midwife. It is clear in these interviews that midwives had an abundance of knowledge about childbirth, about relationships and about women's lives, gained through experience rather than formal education, and that they applied this knowledge in their midwifery practice. For most of the first half of the 20th century there was little open discussion about sexual matters and women had no access to education or books to help them. The midwives talked about women's lack of knowledge about their own bodies, about sex, about contraception and about childbirth (Leap & Hunter, 1993).

> *They didn't know where it was going to come out. But they knew where it went in didn't they? Well, it's got to come out the same place. But they're so dense some of them. I think some of them think it comes out in a bladder, like a balloon, or through the belly button. They think their belly opens. I said, 'It won't come out through there'. And they soon found out that it wouldn't.* (Mrs G. quoted in Leap & Hunter, 1993, p.78).

But they also expressed midwifery knowledge gained through experience and talking with other midwives and women. For example Mrs G. described a 'linking pain' that indicated to her that the woman was nearing the second stage of labour.

> *...you have a pain, and just as its going, it comes back, you see. And then, of course, when they have a second sort of pain with the linking pain, then soon the head starts to show* (Mrs G. quoted in Leap & Hunter, 1993, p.164).

While these quotes come from British midwives, there is no reason to think that New Zealand midwives would have been any more educated. As in Britain, New Zealand women in the early 20th century had no formal access to sex education or information about contraception. What little information existed was prohibited and the first Family Planning Clinic did not open until 1953 (Coney, 1993).

Thus the first professional midwives in New Zealand were influenced by the socio-political context of which they were part and the midwifery profession was also shaped by these outside factors. Midwives gained an identified area of expertise, limited entry and specialised training through state registration provided through the 1904 Midwives Act. As a British colony New Zealand's health system was heavily influenced by Britain and until midwifery education programmes commenced in 1905 the majority of qualified midwives working in New Zealand came from Britain. The 1904 Midwives Act was passed only two years after midwives achieved registration in Britain, and the British experience influenced Grace Neill when she drafted the Midwives Bill (Neill, 1961).

Like their British counterparts New Zealand doctors also opposed midwifery registration and attempted to use similar demarcationary strategies as those described earlier (Witz, 1992). Doctors tried to defeat the legislation while it was still at the stage of a Bill but did not succeed, thanks to Grace Neill's careful lobbying of members of Parliament and the support she had gained from Premier Richard Seddon (Neill, 1961; Donley, 1986).

However, doctors were more successful in their second demarcationary strategy of de-skilling through which they gained control of the regulatory mechanisms of midwifery.

The 1904 Midwives Act provided limitations to midwives' scope of practice as they were not authorised to *"grant any medical certificate or any certificate of death or still-birth, or to undertake the charge of cases of abnormality or disease in connection with parturition"* (Midwives Act, 1904, section 17). The Act also gave powers of supervision and surveillance to doctors by establishing a doctor as the Registrar, with control over midwifery registration processes, and giving District Health Officers (also doctors) powers to supervise midwives, to suspend midwives in order to prevent the spread of infection and to investigate charges of professional misconduct against midwives (Midwives Act, 1904; Papps & Olssen, 1997).

Thus New Zealand midwives, like their counterparts in Britain, achieved state support for autonomous practice in normal childbirth, but found that men (doctors) mediated the relationship between midwifery and the state. On the other hand midwifery education was not controlled through legislation, other than to require a midwife to have undertaken a period of training, attended lectures at a State Maternity Hospital, attended a prescribed number of cases and passed an examination in order to be registered. As described in Part Four of this thesis, midwifery education at the St Helen's Maternity Hospitals was largely under the control of midwives, as was the provision of maternity care in these hospitals. The Midwives Act 1904 did raise the status of midwives and thereby met one of Grace Neill's aims that a better class of woman would be attracted to midwifery (Neill, 1961).

However, as briefly mentioned in Chapter One, the history of midwifery in New Zealand from 1904 to 1971 was characterised by medicine's continual efforts to further restrict the scope of midwifery practice that eventually succeeded in the removal of midwifery autonomy and in the redefinition of midwives as 'obstetric nurses' who worked under the direction and supervision of doctors. Doctors succeeded in restricting midwifery practice by creating opportunities to extend their own role and authority within the changing historical and social context. For example, doctors quickly saw the advantage in claiming expert

knowledge over pain relief in labour so that this task became one that was controlled by medicine. Women seeking pain relief, therefore, required medical care, and doctors were able to use women's demands for the 'right' to pain free births to support their arguments for hospitalised birthing (Mein Smith, 1986). Applying Abbott's analysis, doctor's jurisdiction over pain relief enabled them to successfully compete with midwives for clients, thereby increasing their dominance over maternity work (Abbott, 1988). These gains were then secured through legislation such as the 1938 Social Security Act that provided for free maternity care for every woman under the doctor of her choice. Further discussion of this period of midwifery's history can be found in Part Four of this thesis.

I will now look at midwifery as a workforce. This was the pre-professionalised stage where midwifery was a legislated and named group but did not have the attributes described in Chapter One as being part of a profession.

Midwifery as a workforce

Between 1971 and 1990 midwifery could not be regarded as a profession in its own right. As discussed above it was a workforce that was subordinate to both medicine and nursing. Midwives lost their professional autonomy and were placed in the role of 'obstetric nurses,' carrying out tasks delegated to them by medicine. Midwives were actually redefined as nurses under policy of the New Zealand Nurses Association (NZNA, 1981). Midwifery lost its separate midwifery training programmes when the hospital-based programmes were closed and midwifery was incorporated as a shorter course within an advanced nursing programme in 1979. Midwives were industrially and professionally represented through the New Zealand Nurses Association (NZNA) and although they established a special interest group, the Midwives Section, in 1969, they had no real political power within the wider nurse-dominated association. The majority of midwives were employed and practised in hospitals, in settings that fragmented and medicalised childbirth and functioned through nursing and medical hierarchies. The few domiciliary midwives still practising in the community were the targets of some obstetricians and nurses who sought to stop homebirth and bring all pregnant women into hospital under medical authority.

As mentioned in Chapter One, and discussed more fully in Parts Three and Four of this thesis, it was the establishment of a separate professional organisation for midwives, the New Zealand College of Midwives (NZCOM) that provided a focus for midwifery to reclaim its identity. It was the partnership of politically active midwives (first through the Midwives Section and then through NZCOM) with politically active maternity consumers that resulted in the reinstatement of midwifery autonomy through the 1990 Amendment to the Nurses Act 1977. Although midwifery achieved professional status and a separate identity through legislation, we still operated largely as a workforce at that time.

The next section of this chapter provides a general overview of New Zealand midwifery's professionalisation and identifies four professionalising strategies employed by midwifery to make the shift from workforce to profession. These are: partnership relationships with women, leadership through the professional organisation, education for midwifery autonomy, and self-regulation within midwifery professional frameworks. While each strategy is explored separately in Parts Two, Three, Four and Five of this thesis, the distinctions are artificial as there is considerable overlap and integration in these strategies as the midwifery profession has evolved.

Workforce to profession

In exploring the shift from workforce to profession I will discuss: why midwifery needed to reclaim professional autonomy; how midwifery defined professionalism; how midwifery's notions of professionalism were reflected in the structure of the professional organisation; and why New Zealand midwifery has defined professional autonomy as partnership with women.

Motivations

It was the loss of identity and threat of extinction that drove New Zealand midwifery to seek professional status through legislative change. Midwifery was frustrated by our lack of 'voice' within the nurse-dominated professional organisation of which midwives were

members, and increasingly concerned by actions of both nursing and obstetrics that restricted midwifery practice, downgraded midwifery education and redefined midwives as obstetric nurses – a specialty area of nursing practice and a subordinate role to medicine.

In seeking professional status midwifery sought autonomy of practice in the area of normal childbirth (in line with the International Confederation of Midwives Definition of a Midwife[i]) and self-determination as a profession in order to control our education, set our standards of practice and code of ethics, and establish our regulatory mechanisms.

It was the political partnership with maternity consumer organisations and individual women from the mid-1980s onwards that influenced New Zealand midwifery to prioritise another, even more important, reason for midwifery autonomy – the right of women to control childbirth. Some midwives had always recognised the lack of power that women experienced within the maternity services and had been motivated to change this. However, for many midwives it was the close political partnership with women in the late 1980s that helped them to clarify their understandings of midwifery's role in supporting childbirth as a normal life event rather than a medical process. Therefore in seeking professional status midwifery was seeking autonomy and self-determination not only for the midwives but also for women during pregnancy and childbirth. As stated by Ann Oakley and Susannah Houd (1990, p.114):

> *The exclusion from childbirth of autonomous midwifery restricts the care options available to childbearing women and inevitably promotes the definition of childbirth as a pathological, medicalised process.*

It was essential for midwifery to regain our professional status if we were to do anything to challenge medicine's domination of maternity services and society's understandings of childbirth as a medicalised and hospitalised event. Midwifery needed to achieve professional status so we could control the setting of birth and develop an alternative body of knowledge about childbirth that could challenge the dominance of the medical paradigm in childbirth services. As American sociologist, Barbara Katz Rothman noted:

> *I have come to see that it is not that birth is 'managed' the way that it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed. And the way childbirth has been managed has been based*

> *on the underlying assumptions, beliefs, and ideology of medicine as a profession* (Katz Rothman, 1984, p.304).

Midwifery needed to move from a workforce to a profession if we were to develop a women-centred body of knowledge about childbirth and be able to support women to take back control of birth.

Defining professionalism

Midwives and women were concerned however, about what professionalism might mean, particularly as lay understandings of models of profession emphasised authority of the professional, the power of the professional over the client, barriers to entry to the profession and educational and regulatory mechanisms that separated professions from their client base (Donley, 1989). These traits of professions were antithetical to midwives who, by the mid-1980s, were beginning to see themselves as a group aligned to women. Women consumers also did not want midwives to merely replicate the authority and dominance of medicine. A new model of profession had to be developed.

From as early as 1986 midwives discussed and articulated their core values as they attempted to shape their concepts of profession. Important early work was an extensive consultation process that led to the articulation of a philosophy and set of practice standards for the Midwives Section (NZNA, 1989). These were later adopted by the New Zealand College of Midwives and a code of ethics was developed. Although amendments have been made over the years, these statements continue to express a clear definition of midwifery as a profession and its core values and ways of working that shape all our professional mechanisms (NZCOM, 2005). For further discussion about the debates and consensus decision-making process that articulated midwifery's underpinning philosophy see Part Three of this thesis.

A central philosophical stance relates to midwifery's relationship with women. In 1989 the Midwives Section Philosophy stated, *"Midwifery care takes place in the context of mutual support. Clients play a role in shaping midwifery"* (NZNA, 1989 pp. 8, 26). In the next version in 1992 NZCOM replaced these words with, *"Midwifery care takes place in*

partnership with women. Continuity of care enhances and protects the normal process of childbirth" (NZCOM, 1992, p.2). This philosophy of partnership was also articulated in the Code of Ethics and Standards for Practice (NZCOM, 1992, p.5, 12). Midwifery's understanding of ourselves as a profession *in partnership with women* became the central definition of our professional project. Whilst not claiming authorship I did play a central role in the development and writing of these documents. I attended every meeting and helped craft the words that expressed our understandings and I also had editorial responsibility and oversight of the process of publication for the first 'Midwives Handbook for Practice' through which these statements were disseminated to the wider profession and the public (NZCOM, 1992).

Establishing a professional organisation

When midwifery finally separated from nursing and established our own professional organisation in 1989 we were committed to establishing a structure that would not replicate exclusive and male dominated models of profession, such as medicine (Donley, 1989). Through shared political activity with women midwives increasingly understood that *"the only real power base we have rests with the women we attend"* (Guilliland, 1989, p.14). Midwifery did not want to establish a structure that created barriers between midwives and women. Midwifery also recognised that the socio-political context was changing and that traditional models of profession were no longer appropriate in a climate that valued the rights of people to information and input into their own health care.

Coincidentally but symbolically, the last National Midwives Section conference opened in Auckland in 1988 on the same day that the Cartwright Report on the Cervical Cancer Inquiry was published. This landmark inquiry of 1987 – 1989 into the denial of women's rights to informed consent at National Women's Hospital in Auckland resulted in wide-reaching changes in relation to consumer rights and professional-client relationships (Committee of Inquiry into Cervical Cancer, 1989).

New Zealand midwives wanted to include maternity consumers as active and equal members of the New Zealand College of Midwives to highlight the interdependent

relationship of midwives and women and also to make clear our intention to establish a professional model in which power is shared with women and midwives are accountable first to women and then to the profession. To this end a working group of midwives and women (maternity consumers) was formed to draft a constitution for the new professional organisation that reflected this new style of profession-client relationship. I was a member of this 16-person working party as were Karen Guilliland, Joan Donley and maternity activists Judi Strid and Lynda Williams.

The working group consulted widely with midwives and women about possible structures and processes and information and progress reports were shared back through Midwives Section newsletters[ii]. The resulting constitution was unique and it established places as of right for women at local, regional and national level. It ensured a process for consumer participation on an equal basis with midwives, in policy development and all other structures and processes of the College. It also provided for consensus decision-making, which has become the central decision-making process of the College, with voting only occurring at Annual General Meetings.

The commitment to consensus decision-making resulted from the feminist philosophies of particular working group members such as those named above. However, we also recognised that feminist processes such as consensus decision-making were appropriate for a non-hierarchical organisation that valued the participation of all members and a collaborative and inclusive approach to all its activities, emancipatory and otherwise (Eldridge Wheeler & Chinn, 1991). As Karen Guilliland, the inaugural NZCOM President, wrote in 1989, *"With the support of New Zealand's strong women's consumer movement, midwives both personally and through the College membership, can play a leadership role in changing the system to give women back the control over their birth experiences"* (Guilliland, 1989, p.14).

The central emancipatory intent of midwifery is to improve women's lives, particularly in relation to their childbirth experiences, by challenging the ideologic, structural and interpersonal conditions that oppress women. In midwifery's case this means working with

women in ways that support and empower them, and challenging patriarchal institutional structures that still dominate the maternity services and influence wider societal understandings of childbirth. From its beginnings the New Zealand College of Midwives has claimed that we are a feminist profession (Pelvin, 1990; Guilliland & Pairman, 1995). By this we mean we are a gendered profession that works to support both childbearing women and midwives to claim their own power and liberation (ibid).

Internationally midwives are also beginning to explore feminism in relation to midwifery. While being a feminist is a personal world-view and life journey, as a profession midwifery understands the power of patriarchal ideology that prescribes what is 'natural' for women, what they can know, how they can give birth and mother their children and what counts for expertise in relationship to childbirth. A feminist midwifery profession:

> *Does not attempt to deny the power of its own authority but uses that power in support of women. It also supports and values the women who work within it, asking them to work in solidarity with each other and with the woman in their care in order to help all women have the birth experience they deserve* (Kaufmann, 2004, p. 9.)

The way that New Zealand midwifery does this is through our organisational structure and processes and through our relationships with women. Through negotiated partnerships midwives recognise the realities of the lives of each woman they work with and aim to encourage and support each woman's agency and autonomy. Midwifery partnership has been recognised as a distinctly feminist form of professional practice because it uses *"particular constructions of gender and expertise...as discursive resources in the struggle to obtain and consolidate autonomous status"* (Tully, 1999, p.220).

Achieving autonomy and claiming partnership

Midwives and women were successful in their campaign to regain legislative midwifery autonomy and this was achieved through the 1990 Amendment to the Nurses Act. The details of this campaign and the provisions of the Act have been discussed elsewhere (Donley, 1989; Guilliland, 1989; Pairman, 1998a; Guilliland, 1998; Tully, 1999; Pairman and Guilliland, forthcoming) and will not be addressed in this doctorate.

The 1990 Amendment to the Nurses Act 1977 gave midwifery a socially sanctioned mandate for professional autonomy. Midwives were freed from medical authority (at least on paper) over the provision of normal maternity care and were able to establish their own model of profession.

Before this, however, midwives had already begun to articulate their understandings of what professional autonomy might mean in relation to the women with whom they worked and to their philosophy of partnership. While midwifery sought authority over midwifery practice we never sought authority over the women for whom we provided care. Midwifery claimed our professional relationship with women as 'partnership' and this notion that midwives work in partnership with women underpinned the development of midwifery professionalism. As described above, midwifery actioned this belief through the way we structured our professional organisation, the New Zealand College of Midwives, and the professional framework we established through our statements of philosophy, ethics and practice standards and our later development of the quality assurance process, Midwifery Standards Review (NZCOM, 1992, 1993, 2002, 2004, 2005).

This philosophical notion of partnership was applied to midwifery practice and articulated in the 1995 publication, 'The Midwifery Partnership: a model for practice', written by Karen Guilliland and me (Guilliland & Pairman, 1995). It was written to assist midwives to understand how partnership could be practised in their day-to-day midwifery work and why a partnership relationship between midwives and women was so important if midwifery was to succeed in its aim to share power 'with women' instead of exercising power 'over women'. We said,

> *When articulating midwifery as a partnership of equal status midwives have redefined the accepted view of professionalism. Instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that women can control childbirth. Midwifery must maintain its women-centred philosophy to ensure that its control of midwifery never leads to control of childbirth* (Guilliland & Pairman, 1995, p.49).

Women supported midwifery's claim for professional autonomy because it was made on the basis of specific expertise over an area of work, 'normal' childbirth, and to provide

women with an alternative to the dominant medical model approach to maternity care. It was this public support, along with a number of other contextual influences, such as socio-political support for women's issues and expectations of professional accountability that enabled midwifery's claim for professional autonomy to succeed. Women therefore, had the right to expect that midwives would deliver on their promises. These meant that midwives had to action their autonomy and begin to practise independently of doctors.

> *Women gave midwives a social mandate for practice thereby redefining midwifery as an independent profession. This professional identity carries with it a moral obligation to provide the service women called for and which only midwives can provide. Without independent practice provided throughout the whole maternity experience, midwifery reverts to an occupation, midwives lose their 'with women' status and women lose the opportunity for an alternative childbirth service* (Guilliland & Pairman, 1995, p.39).

For a new profession, in which the majority of members were employed in medically dominated institutional settings and whose education and practice to this point had largely provided no preparation for independent practice, this was always going to be a challenge. That, in only 15 years, midwifery has succeeded in moving from an employed workforce to a profession that now provides independent midwifery care to 73% of childbearing women is truly remarkable. Of course it has not been easy and midwifery and individual midwives have faced, and continue to face, resistance and hostility from many quarters as they challenge *"the predominant patriarchal definitions of women and their ability to make autonomous decisions about their bodies"* (Guilliland, 1998, p.20).

To achieve this success and develop the midwifery profession that exists in New Zealand in 2005 midwifery has utilised four key integrated professionalising strategies of partnership, education, leadership and self-regulation. Each of these strategies is explored through the portfolio work in Parts Two, Three, Four and Five of this thesis.

Conclusion

This chapter has set the scene for further in-depth exploration of New Zealand midwifery's professional project. I have shown how midwives at the beginning of the 20th century achieved state support for registration despite medical opposition. However, their practice

was limited by the demarcationary de-skilling strategy employed by medicine, whereby midwives had practice autonomy in relation to normal childbirth but their regulatory processes were controlled by medicine. However, medicine quickly incorporated all scientific and technological advances, such as pain relief drugs, into its practice and used this expertise to extend its control over normal childbirth. Eventually in 1971 medicine succeeded in its inclusionary strategy and the 1971 Nurses Act removed midwifery autonomy, defining midwives instead as 'obstetric nurses' who practised under the supervision of doctors.

This chapter does not explore in depth the joint political process of midwives and women that achieved the reinstatement of midwifery autonomy through the Nurses Amendment Act 1990 as this is covered elsewhere. Once midwifery autonomy was restored New Zealand midwifery set about establishing a profession that operated from a philosophical base of partnership with women. This was operationalised through four integrated professionalising strategies: partnership relationships with women; leadership through the professional organisation; education for midwifery autonomy and self-regulation within midwifery professional frameworks.

These strategies are explores in the next four parts of this thesis, beginning now with Part Two, Midwifery Partnership.

Part Two: Midwifery Partnership

Part Two: Midwifery Partnership

Part Two of this thesis explores New Zealand midwifery's first key professionalising strategy, partnership relationships with women. I will begin by discussing why New Zealand midwives claimed partnership as foundational to our identity and what partnership means in the context of midwifery professionalism. Next I examine the implications of partnership for the profession and the professional structures and behaviours that had to be put in place if partnership was to be more than just an intention. In order to integrate partnership into midwifery practice and professionalism it was necessary for the notion of partnership to be understood and owned by the wider profession. It was also necessary to develop professional structures and processes that reflected the practice of partnership. These professional structures and processes will be discussed further in Part Three.

I move on to examine some of the critique of partnership that has come from within New Zealand and I also explore international research that lends weight to the notion of midwifery as a partnership between midwives and women.

Finally I introduce the three portfolio pieces that further explicate and develop the themes discussed in Part Two.

Partnership relationship with women

Why partnership?

By claiming partnership as foundational to our professional identity New Zealand midwifery has developed an alternative model of profession. In this model midwifery's first allegiance is to the women we work with and the professional/client relationship is more equitable, reciprocal and personal than those represented by traditional authoritarian models of profession (Ehrenreich & English, 1973; Katz Rothman, 1991; Page, 2000: Kirkham, 2000). In recognising the importance of 'partnership' to their professional identity New Zealand midwives drew not only on their experiences of the political partnership between

women and midwives, but also on their cultural understanding of partnership as citizens in a bicultural nation (Guilliland & Pairman, 1995).

New Zealand's constitutional foundation is the Treaty of Waitangi, a formal agreement made between New Zealand's indigenous peoples, Maori, and the British Crown representing new settlers who came to New Zealand from the early 1800s to establish a new British colony. The Treaty was signed in 1840 to ensure a rightful place for both in New Zealand and to govern the relationship between Maori and the Crown. Inherent in the Treaty are the principles of partnership, participation, protection and equity. Partnership is understood to be mutually defined and negotiated on an equal basis, with full participation of both partners and ensuring the protection of each (Ramsden, 1990).

Although signed in 1840 the Treaty is still seen as relevant today. Indeed ongoing disputes between Maori and the Crown in relation to ownership of land and access to resources have provided a focus for public debate on the meaning of the Treaty and of partnership, such that the notion of partnership is now culturally embedded in New Zealand society (Durie, 1998). 'Partnership' is part of everyday language in New Zealand and is used to describe a variety of social, political, cultural and economic relationships. Increasingly it is used to describe relationships in which imbalances in power and status are recognised and attempts are made to redress these imbalances through negotiation between both partners. It was these kinds of relationships that midwives and women wanted to exemplify by integrating partnership into midwifery's professional identity.

Through writing 'The Midwifery Partnership: a Model for Practice' Karen and I were able to articulate for midwives the meaning of partnership in their day-to-day practice with women (Guilliland & Pairman, 1995). We stated that midwifery partnership was:

> *A relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding. It is this sharing relationship which constitutes midwifery and it is one which spans the life-experience of pregnancy and childbirth. Because of the individual nature of the relationship, midwifery's practice of partnership is a personal one between the woman and the midwife ...Because midwifery recognises the social context of all women, the partnership is also a political one at both a personal and organisational level* (Guilliland & Pairman, 1995, p.7-8)

The Midwifery Partnership Model identified a framework for practice that was required if midwives and women were to achieve partnership relationships. The elements of this framework were: recognition and understanding of pregnancy and childbirth as normal life events; recognition that midwifery is professionally independent of other disciplines; recognition that midwifery works in a continuity of care model providing care to women throughout the entire childbirth experience; recognition that midwifery is about ensuring women are in control of their own birth experiences and that midwifery services meet women's needs (Guilliland & Pairman, 1995).

Integrating partnership

Therefore the practice of partnership required the profession to put a number of professional structures and behaviours in place. Midwives had to take on the values and norms (culture) of the profession, such that they internalised New Zealand midwifery's worldview, were committed to midwifery's ideals and dedicated to providing skilled and knowledgeable care. Midwives had to develop and sustain practice models that supported continuity of care and independent practice. Midwives had to learn to work in partnerships with women and to understand the meanings of terms such as 'autonomy', 'responsibility' and 'accountability' in relation to midwifery partnership. Midwifery had to develop professional frameworks that supported and enhanced midwifery partnership. Achieving midwifery professionalism founded on partnership was an essential part of moving midwifery from a workforce to a profession and a significant part of the activity of the New Zealand College of Midwives and midwifery education processes.

Professional frameworks alone were not sufficient. Leadership, vision and political activity through the New Zealand College of Midwives were also required. Midwifery education programmes were required to appropriately prepare new midwives entering the profession and to meet the continuing education needs of practising midwives. These education programmes needed to reinforce midwifery's values, develop understandings of midwifery partnership and begin the development and articulation of midwifery's knowledge base.

The New Zealand College of Midwives worked in partnership with the Nursing Council of New Zealand as the regulatory authority for nurses and midwives until the Midwifery Council of New Zealand was established in 2003. The College was able to influence the development of regulatory processes for midwives that also recognised and supported midwifery partnership as foundational to midwifery practice and midwifery professionalism. Midwifery Partnership is therefore inherent in each of midwifery's professionalising strategies. It defines New Zealand midwifery as a profession and it structures midwifery professionalism.

Liz Tully's doctoral work on the professionalism of New Zealand midwifery identified that midwifery partnership is a form of feminist professional practice that was used as a cultural resource in midwifery's struggle to obtain and consolidate professional autonomy (Tully, 1999). She said:

> *In positioning midwives and birthing women as partners who share responsibility for the pregnancy/birth, midwifery leaders drew on radical feminist understandings about the importance of women taking control over their lives and health in general, and their reproductive experiences in particular. This discourse of 'partnership' put feminist concerns about issues of responsibility, control, empowerment and choice in health/maternity care at the centre of midwifery's definition of itself as a profession with a "moral obligation to work in partnership with women". By redefining the professional-client relationship as one of 'partnership', in which each partner contributed knowledge and experience, it also embraced feminist criticism of the hierarchical power relations involved in the doctor-patient relationship and the consequent devaluing of women's knowledge* (Tully, 1999, 164-165).

Critique of partnership

While midwifery partnership is central to New Zealand midwifery's identity and professionalism it has been the subject of some critique. New Zealand midwife Joan Skinner (1999) challenged the notion of equality as central to midwifery partnership claiming that there is an inevitable power imbalance when the partners (the midwife and the woman) have different levels of expertise and different perspectives. Skinner argued that the Midwifery Partnership Model (Guilliland & Pairman, 1995) more properly described a

relationship of 'individual contracturalism' whereby the midwife and the woman make a contract together but this does not necessarily produce a participatory outcome, particularly where the midwife and the woman come from different social and educational backgrounds (Skinner, 1999). Skinner contends that the model does not recognise and account for the unequal distribution of power between a midwife and a woman (ibid).

United Kingdom (now Australian) midwife, Nicky Leap agrees that the midwife/woman relationship is based on mutual respect and trust and has the potential for reciprocal learning and mutual personal enrichment. However, she believes that to describe the midwife–woman relationship as between equals denies what she sees as an inherent power imbalance between them (Leap, 2000). Leap contends that women seek midwifery care to access midwifery expertise and that this midwifery expertise means that midwives hold professional power that creates a power dynamic that midwives must understand.

Valerie Fleming (a midwife in the UK with experience from NZ) critiqued the Midwifery Partnership Model (Pairman & Guilliland, 1995) as prescriptive, self-limiting and exclusionist because, she contends, the model *"assumes that normal birth is something for which all women should strive and that midwives only function as midwives in such* [partnership] *environments* (Fleming, 2000, p.201). Fleming concludes that the notion of partnership is *"hackneyed and needs to be revalidated in order to ensure that decisions are taken jointly and that midwives continue to work in the best interests of their clients"* and she suggest that the time has come to reassess the nature of partnership within the midwifery profession (Fleming, 2000, p.205). The basis of Fleming's claim is unclear.

Recently a study completed in New Zealand by a midwife and two non-midwife academics (Freeman, Timperley & Adair, 2004) claimed that a partnership relationship between a woman and a midwife does not require equality between the partners. This study involved 41 independent (self-employed and claiming a fee for service from government), domino (hospital-employed caseloading), and core (hospital-employed on shift work) midwives and 37 nulliparous women who were clients of these midwives. Through questionnaires, midwife-initiated tape recordings of their decision-making reasoning, and structured

interviews, this study sought to understand the decision-making processes used by midwives during labour in order to determine whether the women receiving care were satisfied that they were able to work in partnership with the midwife.

It appears from the research report that the methodology of this study is problematic. The authors do not make clear: how many midwives there were in each of the three groups; what models of practice were used; what length of time the midwife and woman knew each other prior to labour; what decision-making processes may have occurred prior to labour; whether a consistent definition of partnership was used; or enough detail about data collection and analysis to assess the validity of the study. The reported findings do not appear to support the conclusions reached by the authors. Of the 41 midwives, 11 described partnership as 'working together with a common aim', eight as 'sharing information', eight as 'joint decision making', three as 'the woman making decisions', two as 'continuity', two as 'relationship' and one as 'sharing power'. Six midwives described partnership as not achievable because the partners were not equal. Findings were reported for only 11 women. Of these, four described partnership in terms of a 'relationship', three as 'teamwork', two as 'joint decision-making' and two as 'sharing information'. Women were reported as making the majority of decisions for low-risk issues (positions, pain management, eating), while midwives made most of the high-risk decisions (slow progress, fetal surveillance, epidural). The report stated that the majority of midwives and woman believed they achieved a partnership.

One difficulty with this study is that it does not make clear how data were analysed. The authors appear to have reached the conclusion that partnership can be achieved without equality because few women or midwives mentioned the concept of 'equality' in their description of partnership. However, it can be argued that the majority do describe concepts that rely on a sense of equality between the midwife and the woman. For example, 'working together', 'sharing information', 'sharing power' and 'joint decision making' all imply equality, meaning *"being on equal terms"* (Oxford Dictionary, 1961). The authors go on to propose a model for decision-making that is based on negotiation between the midwife and the woman and it provides a set of frameworks for defining separate and joint

accountabilities and ethical responsibilities. It is suggested that this model enables power to be shared without the need for equality.

This research, like the others discussed above, appears to have misunderstood the Midwifery Partnership Model (Guilliland & Pairman, 1995). The model does not require the partners to be equal in the sense of *"being the same"* (Oxford Dictionary, 1961). Rather it contends that both partners have equal status and work together on equal terms (equality). Indeed the model emphasises the different expertise that both partners bring to the relationship. It does not deny the midwife's expertise, as after all that is why she is involved with the woman at all – it is her professional expertise that she offers to women. However, the model gives equal weight to the contribution that the woman makes in terms of her knowledge of her self, her own health, her needs and wishes as appropriate to her own circumstances and context. Successful midwifery care relies on participation from the woman and cooperation in her own health care.

If midwifery is to achieve its aim of empowerment and self-determination for each birthing woman, then it needs birthing women to take part and begin to exercise their personal power. This participation is unlikely to be achieved in relationships where the midwife exercises her power over the woman in an authoritarian manner. The Midwifery Partnership Model identifies a process of negotiation as the partners address issues of their respective roles and responsibilities, decision-making, and power sharing to come to mutual understanding and agreement. The balance of power between the midwife and the woman will be influenced by differences in education, class, culture, socialisation and gender and have the potential to destabilise or inhibit partnership if not recognised and addressed. It is therefore essential that midwives recognise and understand their professional power in relation to the birthing woman and their responsibility for working to facilitate the woman's empowerment. When midwives work with women who are not used to exercising their personal power, it is the midwife's responsibility to find ways to work with the woman that will encourage her to begin to make decisions and take responsibility for these. The midwife and the woman may not reach the point where they feel they are working on equal terms, but even making small shifts in the balance of power can be empowering for both.

The Midwifery Partnership Model is a framework, not a prescription. Like all frameworks it rises and falls on the way in which it is understood and the way it is implemented. Because it sets out principles and recognises that each midwife/woman partnership will be different, there is wide scope for midwives and women to practise their partnerships howsoever they wish and in whichever setting they wish. As long as both partners participate and their decisions are mutually agreed without coercion, it is still a partnership.

International perspectives of partnership

As independent models of midwifery have been established in countries such as the United States of America, Canada and the United Kingdom, a small but growing body of international research has provided support for the Midwifery Partnership Model. Canadian midwife, Deborah Harding (2000), reports a small exploratory study undertaken in British Columbia soon after midwives gained legislative autonomy in 1993. 15 midwives working in continuity of care and carer models in the community were interviewed to explore how midwives experience and implement shared decision-making in their practice. Three areas for discussion emerged: the importance of the midwife/client relationship; strategies for conflicts in decision-making; and the notion that the midwife's paradigm of shared decision-making defines midwifery practice (Harding, 2000).

Midwives identified the midwife/client relationship as the foundation of a shared decision-making process. They described the relationship as one of trust, respect and commitment that facilitated communication and enhanced care. Continuity of care was important as mutual trust developed over time. Harding identified the relationship as 'reciprocal caring': the caring promotes the relationship and the relationship promotes the caring. The midwife and client are described as partners and shared decision-making reflects *the equal, collaborative nature of the midwife-client relationship wherein the professional context and the specific expertise of the midwife can be situated as a resource rather than a directing factor* (Harding, 2000, p.83). Harding too, warns that midwives must remain aware of the

potential for asymmetry in their relationships with clients, but expresses the view that the partnership model will help women reclaim their central role in childbearing.

American midwife Holly Powell Kennedy reached similar conclusions from her phenomenological study into the experience of women cared for by nurse-midwives working in continuity of care models (Kennedy, 1995). Data from interviews with 20 women were analysed and meanings were clustered around nine themes. These were: the woman as an individual determines and directs her care; the woman felt cared for within the domain of her family; a caring relationship built on mutual trust and alliance emerged; the qualities and behaviours of the nurse-midwife laid the foundation for the richness of the woman's experience; a sense of safety encompassed the woman's trust in the nurse-midwife's knowledge and ability; time, that most valued commodity, was both given and respected by the nurse-midwife; the woman and her family felt guided in her decision-making and actions based on the information provided by the nurse-midwife; the health and normalcy of pregnancy were the presiding focus of care; a continuous link with the nurse-midwife was repeatedly demonstrated to the woman throughout her care experience. Kennedy (1995) concluded that the midwifery profession should operate from a philosophy that emphasises women's rights to determine their care and shared power and responsibility in the midwife-woman relationship.

Later research undertaken by Kennedy identified three dimensions of exemplary midwifery care through a Delphi study involving 64 midwives across America and 71 of their clients (Powell Kennedy, 2000). These were: the dimension of therapeutics (illustrates why the midwife chooses and uses specific therapies in practice); the dimension of caring (depicts the midwife's relationship with the woman and her family and how she demonstrates caring); and the dimension of profession (how the profession of midwifery might be enhanced and accepted by exemplary practice).

A follow-up study (Kennedy, 2002, 2004) used narrative method and asked participants to tell stories that most reflected their midwifery practice. 14 of the midwives from the previous Delphi study and four of their clients were recruited as participants. The findings

identified congruence with the findings of the prior Delphi study. Three themes were identified: The midwife in relation with the woman; orchestration of an environment of care; and life journeys or outcomes for the woman and the midwife. Midwives were 'present' with the labouring woman in relationships of mutuality, equality and respect. Midwives created an environment in which women's wishes were met, where she was kept safe along the way and where normalcy was supported and protected. Interventions were used selectively on the basis of clinical judgement and women's wishes and the midwives talked about 'the art of doing nothing'. Midwives described transformative experiences for women as well as their own growth and learning, and at times humility. Kennedy concludes that such models of care have the potential to improve health outcomes and thereby reduce healthcare costs (Kennedy, 2004).

These studies all identify the midwife-woman relationship as foundational to a certain type of midwifery practice; that is practice which is: participatory, seeks to support and enhance normalcy and works to encourage women's self-determination. The midwife-woman relationships are not named as 'partnerships' but they easily could be as they are characterised by equality, mutuality, reciprocity, and power sharing.

United Kingdom midwife, Denis Walsh (1999) explored women's perceptions and experiences of labour and birth within a caseload model of midwifery care whereby two midwives work in partnership sharing their caseload of women and for whom they offer continuity of care. In this ethnographic study 10 women who had received midwifery care through this partnership caseload practice model were interviewed. The relationship between the midwife and the woman emerged as the primary theme. These relationships were informal, personal, and reciprocal; the midwives were seen by the women as 'enabling' and were described as 'friends'. Again, these descriptions of the midwife-women relationship are congruent with Midwifery Partnership. Interestingly, 'friendship' was identified by the participants in my study of midwife-woman relationships (Pairman, 1998) that also led to refinements to the Midwifery Partnership Model. (See the following portfolio pieces for further discussion). In my study the participants identified the midwife-woman relationship as 'professional friendship' (Pairman, 1998).

Lesley Page and colleagues established an innovative model of midwifery care, known as One-to-One Midwifery, in London in 1993. Midwives worked with midwife partners, carrying a caseload of 40 women each for whom they provided continuity of midwifery care on their own responsibility. The model as described is very similar to the self-employed caseload midwifery practice of New Zealand midwives (see Part Three of this thesis). Evaluations of this model of care demonstrated, amongst other things, reduced intervention rates and increased satisfaction from women (McCourt & Page, 1996).

Extensive research was conducted to explore women's responses to their care and findings showed that women felt confident and in control of their experiences. The personal nature of their relationship with the midwife and the development of this relationship through continuity of care enabled effective communication, information sharing and supportive care (ibid).

Again, although these relationships are not described as partnerships they do share some key elements. Page contends that *"bringing childbearing woman and midwives together in relationships in which the midwife 'works with' rather than 'doing to or for'* can have a profound effect on care that is *"greater than the sum of the parts" ...where women learn about their own capacity to love and care for the baby, and about their own strength and knowledge in the process of pregnancy and birth and the early weeks of the baby's life, and where joy rather than anxiety is the dominant emotion"* (Page, 2003, p.124). In order to 'work with' it is necessary to establish a relationship of equality and reciprocity and power sharing such as midwifery partnership.

Mavis Kirkham's book 'the midwife-mother relationship' brings together perspectives from a number of midwives in the United Kingdom and elsewhere who are attempting to work with women in various contexts in more collaborative ways where power is shared and women are supported to make decisions about their care (Kirkham, 2000). Key themes that emerge from this collection of research, and that need to be explored in midwife-mother relationships, include support, continuity of care, trust, relationship skills, the place of self,

and taking power. The context of midwifery practice can assist or block the development of women-centred relationships (ibid).

Whilst not all this international research identified the midwife-woman relationship as one of partnership, there are a number of concepts common to all models. It is possible to conclude that when midwives and women can get to know each other in a one-to-one relationship over time, that midwifery practice takes on certain characteristics in response to the personal nature of the relationship. Midwives' commitment moves from the profession or the employer or whatever other structures they may work within to focus instead on the woman and her individual needs. Midwives who work in this way express a similar set of values and beliefs: a woman's right to self-determination in her childbirth experience; that childbirth is physiological and needs technological intervention only occasionally; that midwives and women share a reciprocal relationship in which trust and power are shared; and that the midwife's role is one of guardian and facilitator of a life changing process that has far reaching effects.

Whilst partnership is foundational to midwifery in New Zealand it is the congruence of its use in practice, policy, education, politics and regulation that is the hallmark of the uniqueness of the New Zealand experience.

Linking the portfolio

The next section of Part Two of this thesis provides three pieces of work that more fully explicate midwifery partnership as a model for midwifery practice. The first, written in 2000, is a presentation given as part of a panel discussion titled 'Revitalising Midwifery' at the New Zealand College of Midwives Biannual Conference. The second, titled "Midwifery Partnership: working 'with' women" is a chapter written for the 2nd edition of 'The New Midwifery: science and sensitivity in practice", edited by Lesley Page and Rona McCandlish and due for publication in 2006. The third, titled 'The Midwifery Partnership Model: ten years on' is a chapter for a book on the development of the New Zealand

College of Midwives that I am co-writing and editing with Karen Guilliland. This book is also due for publication in 2006.

Each of these portfolio pieces provides a different focus on midwifery partnership. As the concept has evolved over the last fifteen or so years it has become apparent that it is a deceptively simple concept. The complexity that is midwifery partnership becomes obvious through the practice of partnership; be that in a political forum, in education, in policy development and implementation, or in day-to-day midwifery practice with women. Midwives need to share their understandings of midwifery partnership and its practice. It is vital to the future of the profession that this happens, as without midwives fully internalising midwifery partnership the profession loses its identity and its purpose. These portfolio pieces make a contribution to midwifery's evolving understandings of midwifery partnership in practice.

Part Two: Midwifery Partnership Portfolio

List of portfolio pieces

Pairman, S. (2000). Revitalising Partnership. *Panel Presentation*. New Zealand College of Midwives Biannual Conference, Cambridge, September.

Pairman, S. (forthcoming). Midwifery Partnership: working 'with' women. In L. Page & R. McCandlish (Eds). *The New Midwifery: science and sensitivity in practice (2nd edit.).* London: Elsevier Ltd.

Pairman. S. & Guilliland, K. (forthcoming). The Midwifery Partnership Model: ten years on. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

Locating the work

These three pieces provide a sample of work I have undertaken to further explicate the meaning of Midwifery Partnership during the period of study for this Professional Doctorate. Congruent with a 'professional doctorate' these works are a result of my professional practice as a midwifery educator and midwifery leader during 1999 to 2005.

As discussed above in Part Two, midwifery partnership as a key philosophy and practice that has enabled New Zealand midwifery to claim a unique professional identity in partnership with women. Midwifery partnership provides the framework for midwifery's professional structures, educational structures, and regulatory structures and it operates in each of these structures. The centrality of midwifery partnership to New Zealand Midwifery's identity has enabled the profession to practise professionalism in unique ways.

Karen Guilliland and I wrote the Midwifery Partnership Model that now provides a theoretical framework to the practice of partnership between midwives and women (Guilliland & Pairman, 1995).

My continuing work in relation to midwifery partnership is to explore and explain what the concept of partnership means for midwives and for women in relation to the structures and functions of the profession. As an educator I work with students to help them understand the history of New Zealand midwifery and why partnership is such an important concept. I assist students to explore the Midwifery Partnership Model so that they understand the theoretical concepts within it, and I assist them to explore the meaning of these concepts in practise with each other, with the School of Midwifery staff and with the midwives and women they work with.

As a midwifery leader I continue to explore midwifery partnership with the wider profession and with women so that our evolving understandings from the practise of partnership can be articulated.

The first piece in this portfolio is a short speech I gave at the NZCOM conference in 2000. I was invited to be part of a panel discussing the topic 'Revitalising Partnership'. At that time I felt a growing concern that many practising midwives did not understand or value partnership and that it was seen as something that was simple and somewhat meaningless. I was also aware of continuing difficulties in some areas in relationships between caseloading and core (hospital employed, non caseloading midwives) whose roles had changed markedly since 1990. I wanted to remind midwives of the many ways in which partnership is expressed within the structures and practices of the profession and I wanted to remind them of the importance of valuing and respecting each other as midwives, despite differing contexts and styles of practice. The speech is a form of rhetoric in which I did not present a deeply theoretical analysis of partnership but instead sought to describe partnership in terms to which midwives could relate.

The second work does present a deeper theoretical understanding or partnership as it examines the Midwifery Partnership Model and the refinements to the model that were suggested from the findings of my master's research into relationships between midwives and women (Pairman, 1998). However, this piece does not merely present findings from

my master's work. It articulates my evolving understandings that the midwife-woman relationship constitutes midwifery because it is the medium through which midwives provide midwifery care to women. If midwives practise this relationship 'in partnership' with women then it will look very different to more common professional/client relationships where the professional practices with the authority of an expert. Midwifery partnership relationships have far reaching potential for empowerment and emancipation of both women and midwives.

This second piece is a chapter for a midwifery textbook and as such it is primarily written for midwifery students and practising midwives. Unlike the first piece it is not rhetorical but seeks to explain concepts and practice from the basis of research and experience.

The third portfolio piece is also written for a book and it was written jointly with Karen Guilliland. Karen and I are writing and editing a book about the New Zealand midwifery profession that picks up from Joan Donley's (1986) book titled 'Save the Midwife'. There is no published documentation of the evolution of the New Zealand College of Midwives or its part in shaping the midwifery profession and maternity services in New Zealand today. As Karen and I have led many of these changes and have been consistently involved in the midwifery profession since about 1985 we decided that we needed to write this book. It is important to document and explain midwifery's development so that those who come after us will have some sense of midwifery's history (at least our interpretation of this).

We deliberately chose to write the book in a descriptive and personal style because much of what we discuss was our own experience. In the introduction to the book we say:

> *Our own chapters are largely a personal account from two midwives who were actively involved in leadership positions through the changes from the late 1970s and early 1980s through to the present. As with many social change movements, the activity and work required to make change happen often meant that events and activities were not fully or formally recorded. We do not purport that our account is the definitive story. Where possible we have referred to the records that are available through the Midwives Section of the New Zealand Nurses Association (NZNA), New Zealand College of Midwives (NZCOM), Ministry of Health, Ministry of Education, Government, consumer organisations, our personal records and general media. The rest was in our heads.* (Guilliland & Pairman, forthcoming).

The chapter included in this portfolio articulates our reflections on the Midwifery Partnership Model in 2005, ten years after it was first published (Guilliland & Pairman, 1995). We were surprised but pleased to find that we did not want to suggest any changes to the model. While our understandings have evolved as midwives in New Zealand practise partnership, we believe that the central tenets of the model remain valid. This chapter then, provides more explanation to our thinking that we hope will help midwives to interpret the model. We did not realise in 1995 how literally some midwives would take the model. As discussed earlier in Part Two, some midwives have criticised the model as unworkable because the midwife always holds power through her professional status. We do not deny that the midwife has knowledge and power but we have tried to explain how this can be acknowledged and used positively in a partnership so that power is shared and not imposed on the woman.

These three pieces each take a different approach to the discussion of midwifery partnership, but these differences are appropriate to the intended audience.

Revitalising Partnership

Panel presentation at NZCOM Conference, Cambridge, September 2000.
Sally Pairman

Revitalising partnership. What does this mean? I read the title for this session and wondered. Why does partnership need to be revitalised? Has it become commonplace, hackneyed, no longer valued? I wonder. I hear students moan 'oh not partnership again!' I hear the words trip off all our tongues so easily – 'I work in partnership'. And then I hear 'it's only for independent midwives' or 'you can't be in partnership with women who are less educated than you', and I wonder.

It seems to me that in New Zealand we have created something amazing between women and midwives in our childbirth services. The New Zealand model of midwifery partnership is unique in the world. We may not be the only profession to have joined with women to successfully bring about political change, but we are the only midwifery profession in the world to have sustained this partnership. We do this through the organisation of the College, through our Standards Review and Resolution processes, through our political activity and most of all through our daily practice with women. Partnership has become very much part of what we are as midwives, as women and as a profession. It is part of how we define ourselves. It is what has brought us success and it is what gives us strength. But do we value it? I wonder.

I recently attended an International Confederation of Midwives conference in Bali. There were 300 Indonesian midwives and about 40 other midwives from around the Asia Pacific region including Japan, Hong Kong, Australia, Taiwan and Bangladesh. New Zealand received a standing ovation when we talked about partnership. These midwives could relate to the idea of partnership as a ground-up movement, rather than something imposed from the top down. They could see partnership as something they could do in their daily practice with women – something that was achievable in the incredibly difficult and heartbreaking worlds they work in. It was obvious that the idea of partnership excited them, both as women and as midwives.

Just last week I was privileged to spend the week with Nicky Leap and Sally Tracy, two midwives from Australia who came to work with our postgraduate students. They visited a number of birthing facilities in Christchurch and spoke to many midwives from all over the South Island. They too were excited by what they saw in New Zealand – impressed by how the midwives saw themselves as independent wherever they worked and struck by their confidence as midwives. They commented about how much we New Zealand midwives take for granted – that we have achieved a system that enables independent midwifery practice, enables continuity of care, enables LMC midwifery, enables partnership. They told us that New Zealand's reality is still just a dream in Australia, still years away, whereas here we are consolidating midwife-led services and maturing as a profession. One example they mentioned frequently was how much discussion there is between core and continuity midwives and how rapidly we are moving as a profession to value both of these roles as essential to partnership with women.

And then a comment from one of our third year students on placement in Samoa. And I'll read you a sentence from her email to me. *"You know, as students, many of us, my classmates, friends in the class behind, we have all grumbled about 'partnership' and how we felt like the term and the theory was forced down our throats. But not until I've been here where there is complete lack of partnership or anything that it includes, do I realise how meaningful it really is, and how lucky women in New Zealand are".*

So if midwives around the world are looking at us with envy and following our lead in their professional development, why do we think partnership has to be revitalised?

Perhaps because it is ours we don't value it. After all we do tend to think that the rest of the world does everything better than us – we are just this tiny country at the bottom of the world – who are we to think we know anything? Perhaps, like the student, we need to experience the absence of partnership before we can value it. As this new generation of midwives takes over, working in a context where partnership is taken for granted, and without the experience of midwifery before 1990, will they value partnership and what it means? Will they protect partnership and keep women and midwives equal together or will they be bored by the notion, see it as an unobtainable ideal or something that is too hard?

So let's have a look at partnership. What does it mean in New Zealand today?

Partnership operates at every level in our profession. In the College it operates between midwives and the women who represent the consumer organisations who have entered maternity service and health politics with us and who continue to support midwifery. Partnership operates at the political level. We have learned well the effectiveness of entering various political forums side by side with women, of networking, of helping each other in our various campaigns, of supporting each other.

Within the College partnership also operates between Pakeha and Maori as we negotiate together what this partnership means to us as a profession, and as we find ways to help us both to grow.

Partnership operates in education in many ways. Most important is the partnership between the midwifery educators and the midwifery practitioners who provide the essential role models of practice for the students. Midwifery educators cannot provide a successful education for students without this partnership with practitioners. Both play an essential and equally important part. Then there are other important partnerships. Between students and women, between students and midwives, between students and lecturers. All these relationships help students (and us) to learn about partnership.

Partnership operates between midwives. No midwife can work in isolation and over the last ten years midwives in New Zealand have worked out ways to work together, supporting each other, in partnership. And this is midwives working together with a shared caseload of clients as well as midwives working together in the different environments of continuity of care and hospital-based care. I will return to these partnerships later.

At the individual level partnership operates between a midwife and a woman as they work together through the shared experience of childbirth, acknowledging the contribution that each makes and valuing both.

I want to focus on two aspects of partnership in a little more depth. Firstly from the perspective of the midwifery profession as a whole.

New Zealand's redefinition of midwifery professionalism as partnership between midwives and women is unique. Many other midwifery organisations struggle with the notion of professionalism as 'power over' or 'expert'. Partnership allows New Zealand midwifery to find a way to ensure that control of childbirth rests with women. In a partnership midwives cannot be the 'expert'. We have power certainly, but so does the woman. In a partnership both the midwife and the woman utilise their power, and one is not more powerful than the other. Both are equally valued. For the profession, partnership provides a solution to the issues of professionalism. It allows us to use the autonomy that professional status brings to the profession, but does not allow us to impose that autonomy onto women. This view of professionalism as partnership is exciting midwives internationally and other countries such as Britain and Holland are looking to New Zealand's example.

Secondly I want to look at partnership between midwives.

We know midwives need to work together and many midwives now work in arrangements where they and their partner manage a caseload and back each other up so that both can have more work-life balance. But beyond these partnerships we need to understand the partnership between midwives who work in core facility roles and those who work in continuity of care. New Zealand midwifery and New Zealand women need both of these midwives. Whilst we can take heart that 70% of women now choose a midwife as their LMC, that individual midwife/woman partnership does not exist in isolation. Most women still birth in a facility. Despite the move to LMC midwifery, society still considers hospital to be the appropriate place of birth. Society still considers birth to be risky and the context in which we work values technology and is increasingly interventionist. Our epidural rates and forceps rates and caesarean section rates may not be as shocking as many western countries, but they are still on the increase. In this kind of context it is very difficult for women to resist the lure and apparent safety of interventions such as epidurals, especially as we have no culture of normal birthing in society to call on. We are trying to help women gain confidence in their bodies and their ability to birth without intervention. But it is a struggle. Some of us have no real experience of normal birthing to call on either. As midwives we know it in our hearts but it is easy to lose confidence when all around us intervention is offered with certainty and ease. This is where midwives need each other. The midwives in the facilities and the midwives in continuity have an ideal opportunity to work together to support the woman and to support each other. As midwives we want the same things. We want women to be in control of their birthing experiences. We want women to birth strongly and without unnecessary intervention. We want midwives to be recognised as the autonomous practitioners they are. We want women to have continuity of care because we know the benefits it brings. We want the facilities and the maternity services to meet the needs of women and their families over the needs of the professionals or the organisation. The midwives who work in continuity have the privilege of getting to

know the woman and her family over a long period of time and in her own home. The pleasure midwives get from working with women in relationships of trust and partnership is well known. But when the woman and the midwife go into the facility they are no longer on such familiar ground. The hospital is not their place. They are visitors. It may be very familiar but it is not home. I believe that we are beginning to understand that the role of the core midwife in the birthing facility can be vital in ensuring that woman have positive birth experiences. The core midwife is the 'wise woman' of the facility. She does know where everything is. She knows everyone who works there. It is her home ground. And she can smooth the way for her midwife colleague and the woman that she knows so well. The core midwife is in a unique position to 'midwife' the continuity midwife and the woman, helping them to maintain their partnership. The art of midwifery is to watch quietly, creating an environment where the woman can take control, guiding as necessary, assisting if necessary, providing support – being there. This is what the core midwife can do. Helping her midwife colleague to continue to be the midwife for the woman. It takes maturity and generosity, and like midwifery it is often invisible. But more and more continuity midwives are beginning to recognise and value the partnership they have with their midwifery colleagues in the birthing facilities. When you think that it is midwives who run the maternity services – in the community and in the hospitals – we have tremendous opportunity to make those services work the way we want them to for women and their families. It is up to us. And talking together and working out our relationships to make true partnerships between midwives is the first step. After all, we should all be able to choose where we work as midwives to suit the various stages of our lives and personal circumstances. Midwives should be able to move in and out of continuity of care or shift work, as they need to. And this moving around helps us to understand better the role that each plays and how we can help each other to create women centred birthing services. This partnership between midwives is, I believe, our last big challenge. And we are well on the way to making this partnership work.

So, partnership revitalised? I don't think so. But partnership valued, maybe. Partnership is the unique contribution New Zealand midwifery has made to women and to midwives and to the international midwifery community. It is much more than just being nice to women and to each other. It requires hard work and commitment and self-knowledge and reflection. It requires generosity. It can be easily lost – through lack of understanding, through lack of knowledge of our history, through doubt, through negativity, through complacency. At its most basic partnership is about self-determination – for the woman, for the midwife and for the profession. It provides us with a way of being the kind of midwives that women want and the kind of profession we want to be. Midwifery partnership is worth valuing. It is worth writing about. It is worth talking about and sharing with our new midwives. It is worth working at. Midwifery partnership doesn't need revitalising. It is already vital. Let's celebrate this vitality; let's claim partnership with pride.

Midwifery Partnership: working 'with' women

Chapter for 2nd edition of The New Midwifery: science and sensitivity in practice, edited by Lesley Page and Rona McCandlish.

May 2005. [Note this is final version sent to editors; it may be altered through the editorial process]

With thanks to Judith McAra Couper for assistance in the section on Cultural Safety.

<A> Introduction

*"Midwifery **is** the partnership between the woman and the midwife"* (Guilliland and Pairman, 1994, p.6). Karen Guilliland and I made this claim in 1994 as we attempted to explore and describe key aspects of relationships between women and midwives that were evolving in the changing context of midwifery practice in New Zealand in the early 1990s. This change in context for midwifery practice resulted from legislation passed in 1990 that reinstated midwifery autonomy and enabled midwives to once again provide care to women throughout the childbirth continuum on their own responsibility. Over the next 15 years the New Zealand maternity system was reshaped to one that is now both woman-centred and midwife-led (Pairman & Guilliland 2003). One result of these changes is that midwives have become more aware of the importance of their relationships with women and have begun to articulate what this means to midwifery practice. New Zealand midwifery has defined the midwife-woman relationship as one of partnership, and further claims that midwifery itself *is* this partnership relationship (New Zealand College of Midwives, 1993, 2005; Guilliland & Pairman, 1995). It is relationships between midwives and women that provide the medium for midwifery care and where these relationships are equal and negotiated partnerships there is increased possibility for the empowerment and strengthening of both women and midwives (Guilliland & Pairman, 1995; Pairman, 1998; Kirkham, 2000a).

That midwifery is a relationship between a childbearing woman and a midwife seems obvious. Indeed midwives around the world have always embraced the concept of 'with woman' (that is the meaning of the Anglo Saxon word 'midwyf') to define their role as midwives, and many midwives have for some years now identified the importance and centrality of the midwife-woman relationship to midwifery practice (Flint, 1986; Donley, 1989; Pelvin, 1990; McCrae and Crute, 1991; Pelvin, 1992; Page, 1993; Hunt and Symonds, 1995; Sandall, 1995; Powell Kennedy, 1995; Kirkham, 1996).

Internationally then, the midwife-woman relationship has begun to be recognised as different to the more traditional hierarchical relationships between health professionals and clients where health professionals are seen as 'expert' and clients frequently lack power and control over their care. Midwives have actively worked to equalise relationships between themselves and the women they work with and to shift power to those women so that they can control their own childbirth experiences.

In New Zealand this has led to a new definition of midwifery professionalism – midwifery partnership, that now underpins all aspects of midwifery at the political level, within the professional organisation, within midwifery regulation, within midwifery education and, most importantly, within the day to day practice of midwives (Guilliland & Pairman, 1995; Pairman, 1998). In the New Zealand midwifery professional framework 'Partnership' is a philosophical stance, an ethical stance, a standard for practice, a competency for entry to the Register of Midwives and a central component in the definition of the Midwifery Scope of Practice (Midwifery Council of New Zealand, 2004; New Zealand College of Midwives, 2005).

To work with women in an equal relationship such as partnership, requires more than just the will to do this, although that is the first step. Like any human relationship the development of partnership between a midwife and a childbearing woman is a complex process requiring self-knowledge, well-developed communication skills, willingness, honesty, trust, generosity and time. Mavis Kirkham's book 'The Midwife-Mother Relationship' brings together varying perspectives from a number of midwives in Britain and elsewhere who are attempting to work with women in more equal relationships and there is much to learn from their experiences (Kirkham, 2000a).

This chapter provides some guidance from the New Zealand perspective where radical changes to the way that maternity services are delivered has meant that the majority of women now receive care from a known midwife in a one-to-one caseload model. This context for practice has enabled midwives and women to explore their relationships and to identify those elements that characterise many midwife-woman relationships. From these explorations a theoretical framework, the Midwifery Partnership Model, has been developed that can be used to guide midwives and students in their learning and thinking about how to work 'with women' during the childbirth experience (Guilliland & Pairman, 1995; Pairman, 1998). This chapter will provide an overview of the development of the Midwifery Partnership Model, examine the model and its refinements and discuss the implementation of the model, both in practice and in the profession of midwifery in New Zealand. It will also explore the potential for application of this model in countries other than New Zealand.

<A>Overview of development of midwifery partnership in New Zealand

New Zealand is a small and relatively isolated country. Located in the South Pacific it has a population of only 4 million people, and a birth rate of approximately 56000 per annum. New Zealand's nearest neighbour is Australia, three hours away by air. New Zealand's indigenous people, Maori, have lived in New Zealand for about a thousand years. Maori have deep cultural and spiritual connections to the land that, amongst other things, carries with it a sense of joint ownership that embraces family, tribal groups and ancestors across time. British settlers began immigrating to New Zealand from the early 1800s to establish farming, to search for gold and to establish a new colony for Britain. They also brought different cultural values and understandings about, for example, notions of ownership, individualism and the meaning of land. In order to live alongside each other Maori and British settlers had to recognise and acknowledge their differences and negotiate relationships acceptable to both. This recognition and respect of differences and negotiation

of relationships continues today, but it was first formalised through the Treaty of Waitangi in 1840.

<B>Treaty of Waitangi

The Treaty of Waitangi is a *..."formal agreement between Maori hapu and the British Crown [that] took the form of a treaty written in both Maori and English which was signed initially at Waitangi ... in 1840"* (Ramsden, 2002, p.74). Its purpose was to establish a constitutional framework within which both Maori and Pakeha (non-Maori) were assured a rightful place for each in New Zealand. The Treaty recognises the unique place and status of Maori as Tangata Whenua (people of the land) and guarantees Crown protection of Maori taonga (treasures), Maori control over Maori resources, and the same rights and privileges as those enjoyed by the British settlers (Ramsden, 2002). The Treaty governs the relationship between Maori and the Crown and inherent in the Treaty are the principles of partnership, participation, protection and equity. Partnership is understood to be mutually defined and negotiated on an equal basis, with full participation of both partners and ensuring the protection of each (Ramsden, 1990)

Due in part to ongoing disputes between Maori and the Crown in relation to ownership of land and access to resources and the meaning of the Treaty in relation to these disputes, the concept of partnership is now culturally embedded in New Zealand society (Guilliland & Pairman, 1995). 'Partnership' is part of everyday language in New Zealand and is used to describe a variety of social, political, cultural and economic relationships. Increasingly it is used to describe relationships in which imbalances in power and status are recognised and attempts are made to redress these imbalances through negotiation between both partners.

<C>Midwifery Partnership and the Treaty

In New Zealand as in many parts of the world, women frequently experience a maternity service where power and control rests with doctors, midwives and other health professionals, and women's knowledges of childbirth are undermined and unacknowledged. This is particularly so when women birth in hospitals and the power of institutions is imposed on women's childbirth experiences through routine care, protocols and hierarchical systems of care.

New Zealand's maternity services have benefited from the political activities of several maternity consumer organisations that have raised issues and worked to bring about changes since the 1930s (Parkes, 1993). During the latter part of the twentieth century these maternity consumer groups were influenced and strengthened by the political agenda of the international women's health movement that swept the western world in the 1970s and 1980s. A strong political agenda recognising women's rights led to a variety of legislative changes to raise the status of women. A landmark inquiry into the denial of women's rights to informed consent at National Women's Hospital led to widespread acceptance of entitlement for all consumers of health care to principles such as self-determination, patient centred care, cultural sensitivity and health provider accountability (Cartwright, 1988; Ministry of Women's Affairs, 1989). In New Zealand these decades also saw increasing societal awareness of the Treaty of Waitangi and its principles, and so it was not surprising

that when maternity consumers demanded a certain kind of midwife they demanded midwives who could work in partnership with them (Strid 1987, Dobbie 1990).

Midwives too, were influenced by the concept of Cultural Safety developed by Irihapeti Ramsden in 1990 and introduced as part of midwifery and nursing education in New Zealand from 1992 (Ramsden, 1990). Using the Treaty of Waitangi as a foundation Cultural Safety focused on the power relationships that existed in health-care delivery and required nurses and midwives to recognise themselves as *"...powerful bearers of their own life experience and realities and the impact this may have on others"* (Ramsden, 2000, p.117). The model of Cultural Safety was further developed from 1990 onwards, and as will be discussed later, it fits closely with the model of Midwifery Partnership, because both models are about individual relationships in which power imbalances are recognised and addressed.

For New Zealand midwifery, therefore, 'Midwifery Partnership' evolved from New Zealand's unique cultural, social and political context in which the Treaty of Waitangi has a central place. While this unique context was the springboard for Midwifery Partnership, this does not mean that the model is not relevant to other countries. Midwifery Partnership is about relationships between midwives and childbearing women. In all parts of the world women and midwives experience these relationships every day as together they share the experiences of childbirth. The New Zealand model offers one way to explore these relationships and in particular to explore the role of the midwife in working 'with women'.

<B>New Zealand's maternity service

The development of New Zealand's maternity services in the late 19th and early 20th centuries was strongly influenced by the British system, as most of the early European settlers came from Britain and the few trained midwives available had mostly trained in Britain. Midwives were regulated from 1904 when the Midwives Act established registration for midwives and marked the beginning of midwifery training in New Zealand. Women received maternity care in their own homes from midwives and doctors or through the state-run St Helen's maternity hospitals that were established in all the main centres and were run by midwives. From 1938 maternity care was free to all women and it remains so today, with private obstetricians the only group who are entitled to charge women on top of the government subsidy.

In the early part of the 20th century midwifery in New Zealand was a strong and autonomous profession. However, this changed rapidly from the 1920s onwards as both government policies, implemented to reduce the infant mortality rate, and demand for 'pain free childbirth' by women, led to increased medical intervention in childbirth and increased hospitalisation. The role of the midwife was reduced from autonomous practitioner to doctor assistant. This changed scope of practice was reflected in legislative changes that first combined midwifery with nursing and then in 1971, removed the word 'midwife' from the legislation altogether so that midwives were now defined as nurses and were required to work under medical supervision. Throughout these years midwives almost lost their identity as midwives and their sense of themselves as 'guardians' of the normal birth process. Women experiencing childbirth in this highly fragmented, medicalised and hospital-based maternity service also lost their faith in their abilities to give birth without

intervention. By the early 1970s midwifery was at its lowest point and facing near extinction.

It was this near decline of midwifery that led to its re-emergence. Through the 1980s midwives regrouped through political activity to reclaim their identity as separate to nursing and to regain control over their future. During the same years maternity consumer activists were demanding the return of autonomous midwifery, as they believed that only midwives working autonomously would be able to assist them to regain control over their birth experiences. Midwives and women recognised their common goals and, in partnership, embarked on a well thought out political strategy from 1987 onwards to bring about changes in legislation to restore midwifery autonomy. This succeeded in 1990 with the Nurses Amendment Act, which allowed midwives to once again provide care to women throughout the childbirth experience on their own responsibility and gave pregnant women a choice in caregivers of midwives, doctors or both.

This legislation signalled the beginning of a more than a decade of change in New Zealand's maternity service. The service was restructured to ensure that each woman had a choice of caregiver to coordinate or personally provide all care throughout the entire childbirth experience from early pregnancy to six weeks postpartum – a Lead Maternity Carer (LMC). Increasingly the LMCs chosen by women have been midwives and in 2002 some 73% of women had a midwife LMC (New Zealand Health Information Service 2004).

LMC midwives can be self employed, based in the community and paid directly by government or they can be employed by hospitals. In either case they mostly work in pairs or in small groups of three. Often several midwife-pairs will join together to establish a larger group practice, providing more flexibility for unexpected cover such as illness. Now, no matter whether a woman chooses to birth at home, in a birthing unit or in a large maternity hospital, she receives individualised care from her LMC midwife (and her midwife partner) throughout the entire childbirth experience.

This one-to-one caseload model of midwifery practice is now the cornerstone of the New Zealand maternity service. Larger maternity hospitals still require midwives to work on shifts and these midwives, known as core midwives, work alongside and support the LMC midwives when they come into the units with their clients. Core midwives may also provide care themselves to women who have serious complications and require in-patient care or for those women who, for whatever reason, do not have a midwife LMC.

<B>The notion of partnership

Midwifery autonomy regained in 1990 enabled midwives to work in a new way with women. Previously only the few homebirth midwives who practised in New Zealand prior to 1990 had been able to work one-to-one with a woman throughout pregnancy, labour, birth and the postnatal period. After 1990 this opportunity was available to any midwife who wanted to take it up and New Zealand midwives have embraced the opportunity. In 2002 some 40% of midwives reported working primarily in caseload midwifery while 53% reported working primarily in core facility midwifery. The remaining 7% were primarily in administration and management, education, professional advice/policy development or in research, and many of these midwives also provided care

(in a caseload model) to a small number of women each year (Nursing Council of New Zealand, 2004).

With the opportunity for midwives and women to form relationships over a nine - ten month period came new understandings of the nature of these relationships. That midwives and women, as groups, had a relationship of partnership was recognised in 1989 when the New Zealand College of Midwives was formed as the professional organisation for midwives. The political partnership of midwives and women that succeeded in bringing about the 1990 Nurses Amendment Act led to recognition of the interdependence of midwives and women. To achieve their different but related goals, politically active midwives and women's groups had worked together to bring about midwifery autonomy. Through this process midwifery was able to separate from nursing and re-establish itself as a profession in its own right. Similarly women achieved their goals of midwifery autonomy and direct entry education that they expected would bring a new kind of midwife – one who recognised their right to be in control of their own birthing experiences. Reflection on this collaborative political activity saw the New Zealand College of Midwives define the relationship between the midwifery profession and maternity consumer groups as 'partnership' and the slogan 'women need midwives and midwives need women' was coined. In recognition of this partnership the constitution of the New Zealand College of Midwives established consumer representation at every level and consumers are involved in all College processes including decision-making and policy development (Donley, 1989; Guilliland, 1989; Pairman, 1998).

From here it was only a small step for midwives to recognise that their individual relationships with women were also partnerships, or that they should be. In identifying partnership as a central concept from the inception of the College in 1989, New Zealand midwifery was actively working to redefine traditional notions of the professional as 'expert', to a definition of professionalism as 'partnership' whereby both the midwife and the woman make an equally important contribution and power differentials are recognised and equalised (Tully 1999).

Although New Zealand midwives embraced the notion of partnership, it was not until 1994 that any work was done to try and explore what midwifery partnership might mean in practice. In 1994 Karen Guilliland and I wrote 'The Midwifery Partnership: a model for practice' that was published as a monograph in 1995 (Guilliland & Pairman, 1995). This model was an attempt to tease out the components of midwife-woman relationships and to explore the notion of midwifery as a partnership. Through reflection on our own experiences as midwife practitioners, as midwife teachers and as midwife politicians, as well as our discussions and observations of many other midwives and women over many years, we developed a theoretical model to describe Midwifery Partnership (Guilliland & Pairman, 1995). The model appears to have struck a chord with many midwives. It has become a required text in all New Zealand midwifery schools and several overseas. It underpins midwifery education curriculum development in New Zealand as well as some programmes in Australia. The monograph has been reprinted a number of times and seems to be in constant demand from midwives around the world.

In 1996/7 I undertook master's level research to further explore the midwife-woman relationship. Six independent (case loading and self-employed) midwives and six of their clients were individually interviewed and also participated in two focus group meetings. The participants were actively involved in analysis of the data and identification of the emerging themes. At the final stage participants compared the findings of the study with the model of Midwifery Partnership as developed by Karen and myself. Refinements were suggested and the participants teased out midwifery partnership to also mean 'professional friendship' (Pairman, 1998; Pairman, 2000). The next section provides an overview of Midwifery Partnership and discusses the original concepts as well as those modifications suggested later as a result of the study described above (Pairman 1998).

<A>The Midwifery Partnership: a model for practice

Midwifery partnership is defined as,

A relationship of 'sharing' between the woman and the midwife. Involving trust, shared control and responsibility and shared meaning through mutual understanding (Guilliland and Pairman, 1995, p.7).

This relationship constitutes midwifery because it is the medium through which midwives provide midwifery care to women within the Midwifery Scope of Practice. The Midwifery Scope of Practice spans the life experiences of pregnancy, labour, birth and new mothering/parenthood to six weeks postpartum and sets the boundaries within which midwifery practice takes place (Midwifery Council of New Zealand, 2004). Midwifery Partnership distinguishes midwifery from other professions involved in provision of maternity care, such as nurses and doctors, and it identifies the unique contribution that midwives have to offer women during the childbirth experience.

Although a single diagrammatic representation of Midwifery Partnership is presented, this is not to imply that all relationships between midwives and women are the same or that all women want the same things from midwives or that all midwives work in the same way. Rather, Midwifery Partnership recognises the individuality of each partner, their differences as people, their different needs and priorities, their different experiences. Because each midwife and each woman brings different dimensions to their relationship, each partnership will be different. A partnership requires both partners to define their relationship, to negotiate how they will work with each other and to define their expectations of the relationship. This negotiation is overt and requires active participation by both partners and clear communication. The negotiated outcomes of each partnership will be different to accommodate the needs of both partners and therefore few partnership relationships will look the same. Because it is a professional relationship it is the midwife's responsibility to initiate the partnership and to work with each woman to achieve this. The model of Midwifery Partnership offers a framework for these different relationships that identifies the characteristics and principles of partnership and can guide midwives in working with women in a more equal and shared way.

<B>The partners

The two partners in a Midwifery Partnership are a midwife and a woman. They enter into a relationship for the purpose of receiving and giving midwifery care and together they share the woman's experiences of pregnancy, labour and birth and the

postnatal period. This nine to ten month experience reflects the Midwifery Scope of Practice and sets the boundaries of midwifery care (Midwifery Council of New Zealand 2004). Through this timeframe a woman and a midwife are able to get to know each other intimately in a way that makes their relationship distinctly different from usual health professional /client relationships.

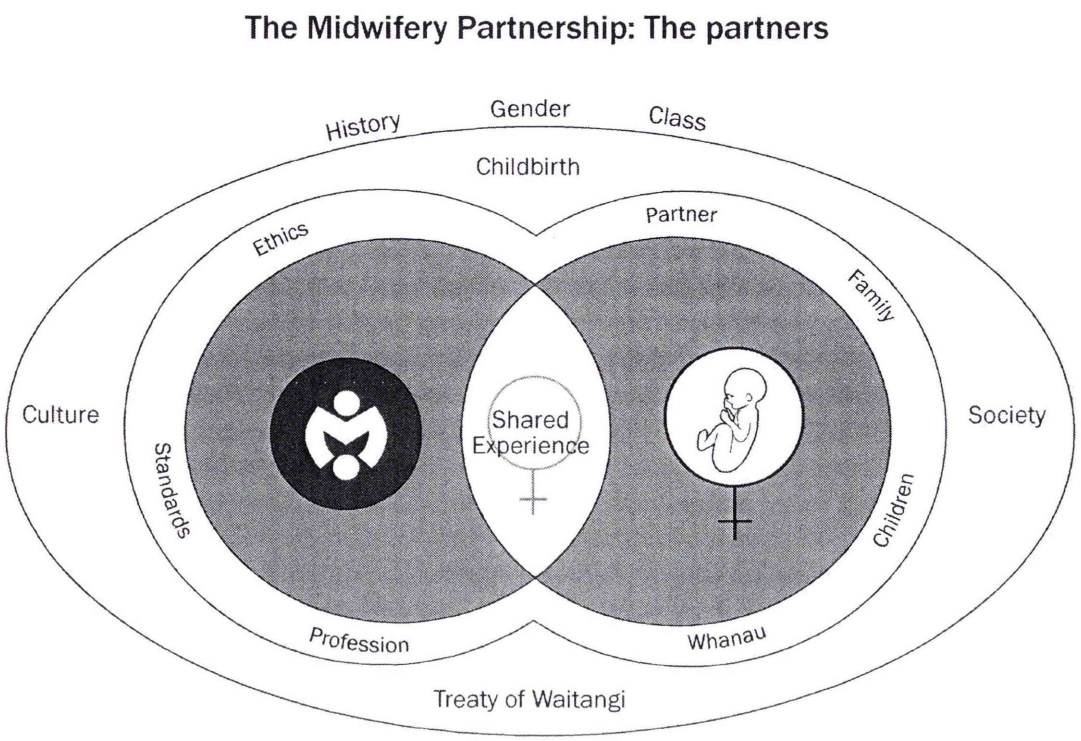
Both partners in a Midwifery Partnership exist within their own social context. As indicated in figure one below, each woman is part of her family (as defined by her) and she will be influenced by the beliefs and values of this group. The baby is depicted within the woman to symbolise the connection between mother and baby. During pregnancy a mother and baby are physically one. After birth the baby exists separately but its mother is recognised as the person who ultimately makes decisions for the baby. For midwifery, the needs of mother and baby are always seen as an integrated whole, *"where the needs of one will be the needs of the other"* (Guilliland and Pairman, 1995, p. 42).

Each midwife too, is part of her social group, but because it is her professional role that enables her to be in a relationship with each of her women clients, the midwife is depicted within the professional framework of midwifery. Her practice will be guided by the philosophy, standards and ethics of the midwifery profession to which she belongs.

Gender, class, history, culture and society shape both partners. As discussed earlier, the Treaty of Waitangi is a unique aspect of New Zealand society. In other countries there will be other societal influences to consider when applying the model. In the revised model another circle surrounding both partners was added to depict the impact that the maternity system, including the place of birth, the wider health system and societal beliefs about childbirth, will have on women and midwives during their experiences of childbirth. In New Zealand and most Western countries, medicalisation is still the dominant ideology of childbirth. Midwifery Partnership attempts to challenge this dominance by offering women and midwives an alternative model for midwifery practice, *"which is emancipatory and equalises power relationships within maternity services"* (Guilliland and Pairman, 1995, p.9).

Figure one below depicts the partnership between the woman and the midwife as two equal and intertwined circles. The equal size of the circles represents the equal status of each woman and each midwife that must be recognised by both partners if a true partnership is to develop. Both partners have acknowledged expertise and make equally valuable contributions; the midwife contributes her midwifery knowledge and experiences and professional framework and the woman contributes her self-knowledge, experiences and needs and desires for this birth. Both partners need the other's contribution to ensure a positive and safe birth experience. The intertwined section depicts the shared experience of pregnancy, labour, birth and the postpartum period that makes up the Midwifery Scope of Practice. The woman symbol in this section indicates the woman-centred focus of the relationship. The principles identified within this intertwined section are important if the relationship is to be a partnership, and provide guidance for how a midwife and a woman can work together.

Figure One: partners



The Midwifery Partnership Model: The Partners
(Guilliland & Pairman, 1995)

Source: Guilliland and Pairman, 1995, p.50.

In the 1998 revision of the model detail was also added to describe more fully the characteristics of each partner and what they contributed to the relationship (Pairman, 1998). The women in my study had certain expectations of midwives and the type of care they were seeking. These women wanted midwifery care based on trust, respect, equality and openness. They wanted to be actively involved in their care, to take responsibility for themselves and to be in control of their childbirth experiences. They also wanted to have this intimate midwife-woman relationship with another woman. As Bizz (one of the women in the study) said:

> *I wanted someone that I could initially build a trust in and get to know leading right up to the birth. Just that more personal and trusting relationship. And hearing the same things from the same person ...it was important that it was someone I could talk to quite confidently, someone approachable...it was important too that she was a woman ... to have an equal relationship* (BF in Pairman, 1998, p.75).

Another woman, Dianne, wanted midwifery care because her previous experiences with doctors meant she did not believe she would get the information she needed to feel safe during her pregnancy.

> *It was a really important event for me, and there were a lot of questions I wanted answered and I suppose from some of my other experiences doctors just don't*

release the information and sometimes I feel they think its not to be released. ... (In my childhood) *we went to see the doctor and he knew everything, so there's still that sort of feeling when you go to a doctor. I go into the surgery and I sit in the chair and he asks "how are you" – "I've got this problem". Whereas you should be able to say you've got a problem and talk to them normally, but you still feel like he's sitting in a big chair and you're sitting in a little wee small chair, going "yeak" and squeaking, thinking 'am I allowed to say what I've got wrong?' Which is not the sort of experience that I want when you're having a baby. You really need to know what's going on and have answers. It's not an illness ... you've got to know all the answers. They're dealing with another human being (D McD in Pairman, 1998, p. 81)*

Dianne's description of visiting her doctor illustrates her perception of the doctor as 'expert' and her own sense of powerlessness in the doctor-patient relationships she has experienced. She indicates that she wants a different type of relationship with her caregivers during pregnancy.

In the woman circle of the refined model I have added the concepts of 'seeking professional care', 'seeking active participation, self-responsibility and control', 'seeking trust, respect, equality and openness' and 'being female' to indicate that women actively choose midwifery care because they are looking for a specific type of professional relationship in which they will have power and control over their birthing experiences.

To some extent the characteristics that women seek from midwives were also mirrored in the concepts that were added to the midwife circle in the refined model. To work with women in a partnership relationship requires a midwife to have certain qualities that become evident through the way the midwife works 'with' each woman. These qualities include the way in which a midwife utilises her knowledge and skill and 'self' in her practice; the way in which she is accessible to women, provides emotional support to women and builds their confidence; and the way she brings herself as a woman to the relationship. As Bizz said;

I trusted her professionalism and all her knowledge, but I felt very equal with her. I needed her expertise and I was very confident in it, but I suppose her confidence built my confidence (BF in Pairman, 1998, p.117).

Sarah, too, talked about the importance of getting to know the midwife as a person and how this led to individualised care that met her needs.

MW and I just seemed to click so we get on really well, we talk about lots of different things...there were a lot of other things to talk about rather than jus the appointment for me to have a baby. I found that I learnt things about MW as she learnt things about me. She didn't expect me to do all the talking about me and my life and how things were going here – she'd tell me how Matthew (her son) was doing and he came with her on acouple of visits. So I got an insight into MW and her family as well...so I don't think she learnt all about me and I learnt nothing about her...its probably only natural that she finds out more about me, because she's got to deal with me through the nine months, and then through the labour and knowing how I'll react and different things – how my past pregnancy had been –

just to find out so she knows so she can do more either actively or by changing the way she might word things. If I was a morning person she'd come in the morning...just different things like that would probably change her... I think the more you can help them and be honest about it the better it'll be for you in the end (SC in Pairman, 1998, p.119).

Amy confirmed this individual approach to each woman when she said:

I think MWs guideline was made by each individual she cam across – everybody lives differently so we all have to have a different set of rules (AA in Pairman, 1998, p.99)

The midwives recognised the active role inherent in being 'with women'. As Chris said about working with women in labour:

I take great delight in supporting. I used to do all the back rubbing and getting this and getting that and now I take real delight in working for them, helping them to work together because it's their birth and I work quite a bit now at not being intrusive and supporting the husband to support the wife rather than just directly supporting the woman. I guess I do that as well but it's using her support people to do the work to provide the support to make her feel cared for and loved and supported and everything else so that you're in the background rather than the foreground (CS in Pairman, 1998, p.101).

When working 'with' women the midwives deliberately used their knowledge, skills, and 'self' to form trusting relationships with women and help women to build and draw on their own resources of support, control and initiative. The midwives were actively present with the women in both a physical and emotional sense, critically reflecting on their practice as a way of developing and trusting practice wisdom. For these midwives, practising in New Zealand in the early 1990s meant that they had to work out what it meant to be independent practitioners, able to care for women on their own responsibility. With this professional autonomy came responsibility and accountability and recognition that 'independence' is an active midwifery role that says more about how the midwife practises than it does about how she is employed or the model of care in which she works. As Kay said:

I see what I do now as a complete job not part of it or bits of it or half of it, because what you and the woman decide antenatally impacts on what happens postnatally...its given me freedom in that I am my own boos and I will make decisions with the woman about what happens (KF in Pairman, 1998, p.73).

And Kate:

I'd like to think that if I went back into the hospital situation, that my whole feeling of practising as a midwife would be different from what it was when I was there...I guess before the Nurses Amendment Act I felt like I was employed and doing a job, and to me now, caring for women and being an independent midwife has got a totally different feel about it than being a midwife working in a hospital...it's a sense of...it's a whole lot more commitment – it's a life commitment rather than a job I guess, that's the difference (KS in Pairman, 1998, p.74).

Thus, to the midwife circle I have added the concepts of 'being female', 'giving support', being accessible', 'using knowledge, skill and 'self' in practice', 'being with', 'developing practice wisdom' and 'practising independently' to further describe what a midwife brings to her midwifery practice (see figure two below).

Midwifery practice is active in that a midwife utilises her knowledge, skills and experiences thoughtfully and with regard to the specific needs of each woman she works with. Even when she appears to be doing little a midwife is observing, analysing and thinking about what is happening and how she can support and enhance what is happening for the woman.

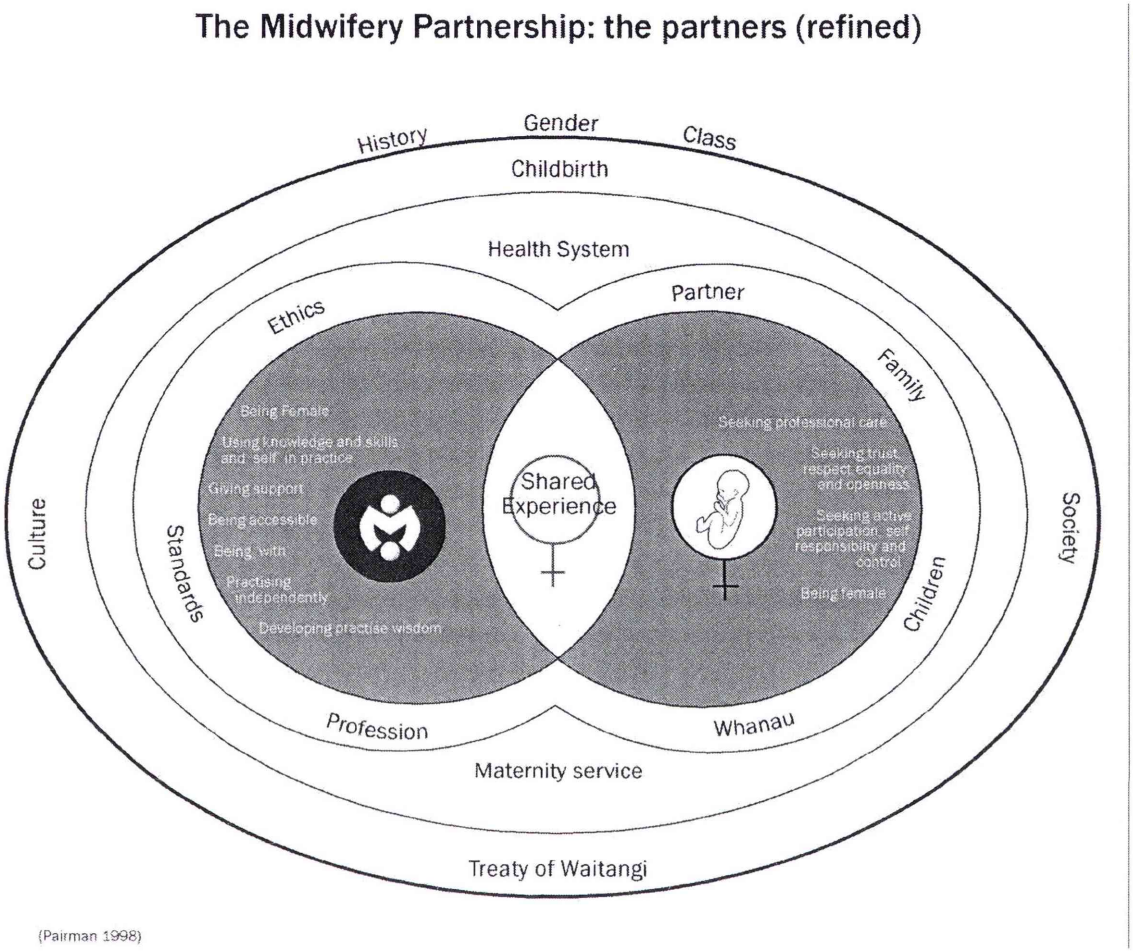
As Chris said:

> *I think that in midwifery caring for the pregnancy is a small part of actually caring for the woman. I think that's where alot of GPs miss out, they care for the pregnancy, the physical part and perhaps some of the emotional part, but whether they actually support the woman with what's going on in her life and the changes she needs to make...if you don't give them the time then they don't get a chance to explore those things* (CS in Pairman, 1998, p.99).

Kate, another midwife, talked of the importance of understanding her own beliefs and attitudes as well as the woman's context in order to provide appropriate midwifery care:

> *It's the whole family dynamics; it's the people that are close to her. It's not just the woman, it's everyone that affects her, and everything that affects her...the more I practice, the more I think where the caregivers and support people are at affects what happens with a woman...I think where the midwife is coming from is really important* (KS in Pairman, 1998, p.99).

Figure two: the revised model (partners)



Source: Pairman, 1998, p. 188.

<B>Cultural Safety

The importance of midwives understanding their own attitudes and value systems and recognising the power inherent in their professional roles and how these factors can all impact on each woman they work with is a key principle in another New Zealand theory for practice, Cultural Safety. Developed by Maori nurse educator Irihapeti Ramsden in the 1980s, Cultural Safety is defined as,

> *The effective nursing or midwifery practice of a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief and disability. The nurse of midwife delivering the nursing or midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans*

*or disempowers the cultural identity and wellbeing of an individual (*Nursing Council of New Zealand, 2002, p.7).

For midwives who are part of the dominant culture such as white, heterosexual and middle class, and in relation to their professional role, have status and power as midwives within a powerful health system, understanding the principles of Cultural Safety can be uncomfortable and challenging. Members of the dominant culture are not taught to recognise their privilege but learn to think of their lives as 'morally neutral, normative and average' (McIntosh 1988 p.16). In other words members of a dominant culture believe that the realities of society are natural and normal, and are the same for everyone.

This notion that everyone should be treated the same is implicit in Transcultural Nursing theory (Leininger 1991) in which midwives (and nurses) were taught the concepts of cultural awareness (becoming aware of difference) and cultural sensitivity (acknowledgement of the legitimacy of difference) from the perspective of the midwife. Such an approach placed power with the midwife to identify the needs of people from other cultural groups and did not require self-knowledge or change in attitude. It also led to development of cultural stereotypes and cultural checklists for care and ignored the existence of power relationships in the delivery of health care (Ramsden 2000). Transcultural Nursing theory places the nurse (midwife) in the position of 'external observer' for the purpose of providing culturally specific care, while Cultural Safety addresses the issue of power between the client (woman) and the nurse (midwife) along with interpreting culture in the broadest possible sense (Ramsden 2002).

> *Leininger's culturally congruent care model is different from Cultural Safety in that nurses and midwives need to move from treating people regardless (my emphasis) of colour or creed towards a model of care that is regardful of all those things that make them unique* (Ramsden 1993 p.5).

Cultural Safety begins with self-reflection and attitude change through a process that requires midwives to recognise themselves as '...powerful bearers of their own life experience and realities' and to understand the impact this may have on others (Ramsden 2000 p.117). The midwife is challenged to recognise her personal power and the power of her professional role and the institutions in which she works (Richardson 2000). Cultural Safety makes visible the invisible structures of power (including our own) and attempts to transform anything that creates inequality. Cultural Safety shifts power from the provider (midwife) to the recipient (woman) by requiring the woman and her family/whanau to decide whether the midwife's care is safe for them (Ramsden 2002). 'Safety' in this context includes not only physical safety but also a sense of emotional, psychological and spiritual safety.

Cultural Safety is primarily about establishing trust, gaining a shared meaning about vulnerability and power and carefully working through the legitimacy of difference (Ramsden 2000). It requires midwives to examine their own realities and attitudes they bring to practice and to understand how historical, political and social processes impact on people's health.

In a midwife/woman partnership relationship the differences between both partners are identified, respected and negotiated. In this way trust is established and relationships are flexible as together midwives and women work with the uncertainty and paradox that difference constantly presents to them (Spence 2004). This takes courage, patience and kindness. Cultural Safety is an instrument that allows a woman and her family to judge if the maternity service and delivery of midwifery care is safe for them (Ramsden 2002).

Although Cultural Safety originated in New Zealand out of a context of biculturalism in which the Treaty of Waitangi was central, it is applicable in other societies and contexts. Indeed as Irihapeti Ramsden said (2002 p.181),

> *Cultural Safety was designed as an educational process by Maori and it is given as koha (gift) to all people who are different from service providers, whether by gender, sexual orientation, economic or educational status, age or ethnicity.*

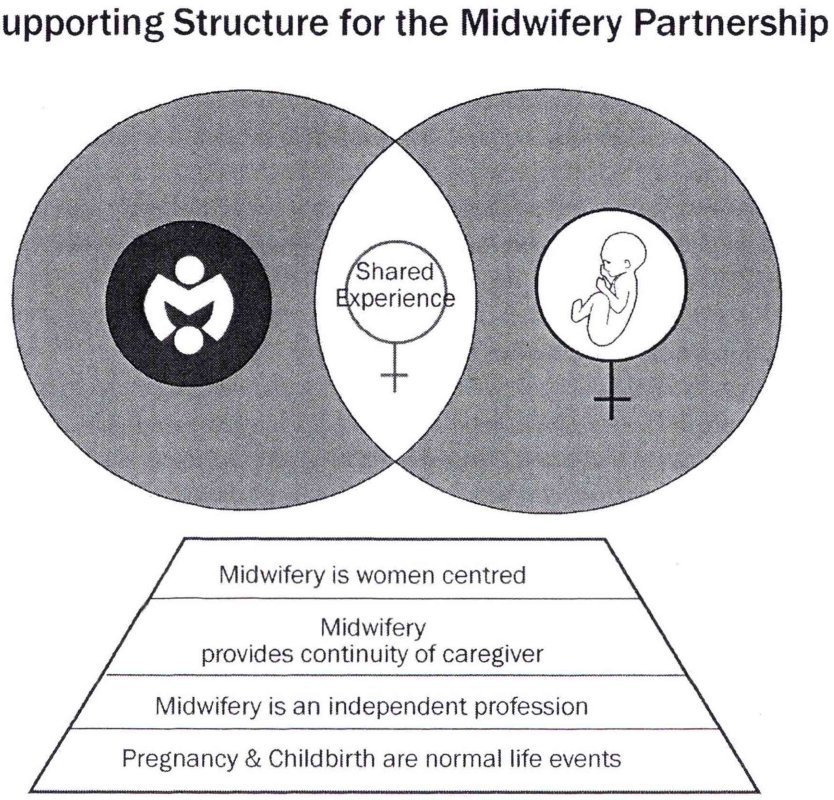
Cultural Safety is inherent in Midwifery Partnership as it provides a framework for recognising cultural 'difference' between a midwife and a woman, the power inherent in the professional role of a midwife and the impact that the culture of the midwife may have on her professional practice. Like Midwifery Partnership, Cultural Safety seeks to shift power from the midwife to the woman by recognising that it is the childbearing woman and her family, not the midwife, who determine that the midwifery care she receives, is effective and 'safe'. Like Midwifery Partnership, Cultural Safety relies on trust. As Irihapeti Ramsden said

> *Cultural Safety is about the formation of trust and the components of trust becoming recognisable to patients (women) ands nurses (midwives). Only when trust has been established can exotic differences be revealed, discussed and negotiated in the actions of giving and receiving nursing (midwifery) care. This often involves the transfer of power from nurse (midwife) to patient (woman) and the renegotiation of traditionally held positions*
>
> (Ramsden 2002 http://culturalsafety.massey.ac.nz/ChapterEleven.htm Retrieved 1.5.05)

<B>Philosophical underpinnings

The formation of a midwifery partnership relies on the midwife, at least, holding certain philosophical beliefs. The woman may also hold these beliefs. They underpin midwifery partnership because they direct and support the practice of midwifery. These beliefs are: pregnancy and childbirth are normal life events; midwifery is an independent profession; midwifery provides continuity of caregiver; and midwifery is women centred (see figure three below). These philosophical beliefs are shared by midwives around the world and distinguish midwifery from other disciplines involved in the provision of maternity care (International Confederation of Midwives 1990, Association of Radical Midwives 1986, Page 1988, 1993, Midwives Alliance of North America 1991, Houd 1993, Midwifery Council of New Zealand 2004, Australian Nursing and Midwifery Council 2005). These beliefs were supported by the participants in my study and their insights added depth to our understanding of these aspects of midwifery practice (Pairman, 1998).

Figure three; Philosophical underpinnings



The Midwifery Partnership model: Supporting Structure
(Guilliland & Pairman 1995)

Source: Guilliland and Pairman, 1995, p.34.

<C>Pregnancy and birth are normal life events

Midwifery knowledge is constructed from the belief that pregnancy and childbirth are normal life events. This understanding directs midwifery practice and defines the role of the midwife as one of *Kaitiaki* or guardian, to support and protect this unique physiological process and transformative life stage (Donley, 1986). The belief in the normalcy of pregnancy and childbirth is one of the main differences between the midwifery and medical models of childbirth. If one believes that childbirth is a physiological process then one's role is to enhance and support that process while still keeping a watching brief to ensure that it stays within normal parameters for each individual woman. If one believes that it is a physiological process that is unreliable, inconsistent and fraught with potential danger then it is necessary to try to control the process to guarantee a good outcome.

At the heart of this is the ability to trust women's bodies and trust physiology. Of course not all births will be straightforward and have a good outcome. However Western societies have embraced science and technology to such an extent that trust in physiology appears to have been lost. Much research and practice has focused on ways to control childbirth in order to guarantee a healthy baby rather than seeking ways to support and enhance physiology. Childbirth services that have been constructed in western societies mean that most women birth in hospitals and experience some form of surgical, technological or pharmacological intervention (Crabtree 2004). Western maternity services not only undermine women's confidence, they also undermine midwifery knowledge and confidence, as midwives are increasingly involved in implementing these interventions. As Downe and others have noted, midwifery's claim to be the guardian of normal birth while apparently implementing a variety of interventions during the childbirth process, is paradoxical (Kirkham 2000b, Downe 2004). Even where models of midwifery care support one-to-one care from a midwife, such as in New Zealand, intervention rates in childbirth continue to rise.

Clearly the physiological process of childbirth is finely tuned and requires not only belief but also recognition of the myriad of interacting factors that can enhance or impede it. These factors may include a woman's personal and familial history, the environment in which she labours and gives birth, the ideology that frames the attitude and response of caregivers, the attitude and expectations of her family and friends and her own fears and beliefs (Downe & McCourt 2004, Crabtree 2004).

A significant challenge facing midwifery today is to recognise the complexity and uncertainty of childbirth and to reframe it as 'uniquely normal' rather than expecting pathology (Downe 2004). Foureur and Hunter (in press) propose a 'package' of care to keep childbirth normal involving a close personal and trusting relationship with a midwife in a one-to-one caseload model; a strong belief in childbirth as normal physiology; and a familiar environment for birth that enhances and supports the normalcy of childbirth. Pairman and Guilliland (2003) have suggested that midwives and women need locations for birth that are not dominated by the medical model philosophy of birth within which they can strengthen their understandings of birth as physiology and reduce their reliance on technological interventions for routine screening and pain relief.

Midwifery Partnership recognises each woman as uniquely normal and when midwives and women work together throughout the childbirth experience and in women's own environments, midwives begin to understand the range of 'normal' that can only be defined individually for each woman (Katz Rothman 1984). When midwives internalise this understanding they begin to challenge their practice and find ways to resist and reframe the dominant medical ideology such that they can once again claim to be the guardians of normal.

<C>Midwifery is an independent profession

Independent midwifery practice involves a midwife practising autonomously from a specific philosophy and body of knowledge without reference to another discipline and taking responsibility for the midwifery judgements made and the actions implemented. Independence is about how a midwife practises and the way she sees her professional role.

It is not about her employment status or where the woman gives birth. Independent practice occurs when midwives provide care across the scope of midwifery practice on their own responsibility.

Autonomy is an important aspect of midwifery's professional identity as it provides midwives with the freedom to make decisions with women rather then being constrained by rules or dictates of other disciplines such as medicine or by the protocols of employers or maternity facilities. A midwife's judgements arise instead from professional standards and guidelines and from discussion and negotiation with each woman. Midwifery care will be informed by evidence when possible and often decisions and uncertainties will be discussed with midwifery colleagues or obstetric specialists, as midwives do not work in isolation. However, the key point about professional autonomy and independent practice is that it allows a midwife and a woman to begin to reframe childbirth as normal and unique to each woman. It allows a midwife and a woman to work together in a way that shifts control to the woman, recognises her active involvement and meets her needs. The woman and the midwife share responsibility for decisions made and the midwife remains professionally accountable for her judgements and actions.

Midwifery Partnership relies on independent midwifery practice so that a midwife can work in partnership with a woman 'to provide the complete service throughout pregnancy, labour, birth and the postnatal period on her own responsibility' (Guilliland and Pairman 1995 p.37). When midwives practise independently and in partnership with women they are no longer seen as 'experts' with power 'over' woman as in 'old' notions of professionalism. Instead Midwifery Partnership provides an example of 'new' professionalism whereby both midwives and women have recognised authority and the midwife's role moves from 'expert' to 'reflective practitioner' whose task is to support, guide and accompany a woman within a more equitable, interdependent and empowering relationship (Tully 1999; Pairman and Donnellan-Fernandez in press). By articulating midwifery as a partnership New Zealand midwives have redefined traditional notions of professionalism. However, midwives need to understand this definition and midwifery needs to reinforce the implications of this 'new' style of professionalism to midwifery practice so that midwives do not abuse their power and authority.

> *Instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that woman can control childbirth. Midwifery must maintain its women-centred philosophy to ensure that its control of midwifery never leads to control of childbirth* (Guilliland and Pairman 1995 p.49).

<C>Midwifery provides continuity of caregiver

Midwifery is the only profession involved in the care of women through the childbearing cycle that provides continuity of caregiver and it is essential that it continues to find ways to do so. Continuity of caregiver enables midwives to work in their full scope of practice and it provides time for midwives and women to get to know each other, to build trust and to build partnerships. When midwife-woman relationships span pregnancy, birth and beyond there is time to work with each woman to discuss her wishes and her fears for birth and motherhood and to build her self-confidence. There is time to work with families to uncover their fears and misconceptions and to build their confidence. Decisions can be thought through over time as information and options are explored. There is time to

talk about what labour might be like, or how each woman might respond to pain; to discuss the impact of the environment; to talk about uncertainty and complexity so that ideally by the time a woman begins labour she is willing and confident to 'let go' and trust her body to give birth.

Continuity of caregiver means 'one midwife (and her backup colleague) providing midwifery care throughout the entire childbirth experience' (Guilliland and Pairman 1995 p.39). Midwives working outside this continuity model (core midwives) provide the essential link and support for the caseloading midwife and the woman to maternity facilities if the woman is birthing in hospital and to obstetric services if the woman requires extra care. As the 'wise women' of the institutions core midwives facilitate the experience of caseloading midwives and their clients, providing practical help and support as required. A partnership relationship between core midwives and caseloading midwives means that women can be assured of a smooth transition between primary and secondary services if necessary and the midwife-woman partnership is supported and protected even as other professionals such as the obstetric team become involved.

Continuity of care is explored elsewhere in this book (see chapter X). Despite the increasing evidence that demonstrates the benefits of continuity of care and one-to-one support in labour to women there are few maternity services outside of New Zealand that have enabled and supported midwives to develop and maintain one-to-one caseloading models of care. However, for Midwifery Partnership they are essential. While midwives have effective and positive relationships with women in other models of practice, it is the time and consistency that come with continuity of caregiver that is so important to the development and practice of partnership.

<C>Midwifery is women centred

'Women centredness' gives primacy to the woman who is the recipient of midwifery care. It acknowledges that midwifery only exists to 'facilitate the optimal experience of birth for pregnant women and their families' (Guilliland and Pairman 1995 p.41). It recognises that it is the woman who is the focus of all midwifery care, acknowledging each woman's individuality and encouraging midwives to work with each woman in whichever way she wants in order to meet her individual needs.

Women centeredness does not deny the important role of the woman's family or deny the importance of caring for the baby. Rather, a woman-centred philosophy recognises each woman's connection and integration with her family and baby and recognises that each woman will decide how she wants the midwife to interact with and involve her family. Women centeredness recognises that a midwife's primary relationship is with each woman she cares for and that this care must be provided in such a way that the woman's individual context is respected. As Bizz explained:

> *The midwife spoke about my pregnancy and a whole thing with me, Eric and the baby, rather than just my body and my baby inside it* (BF in Pairman 1998 p.183).

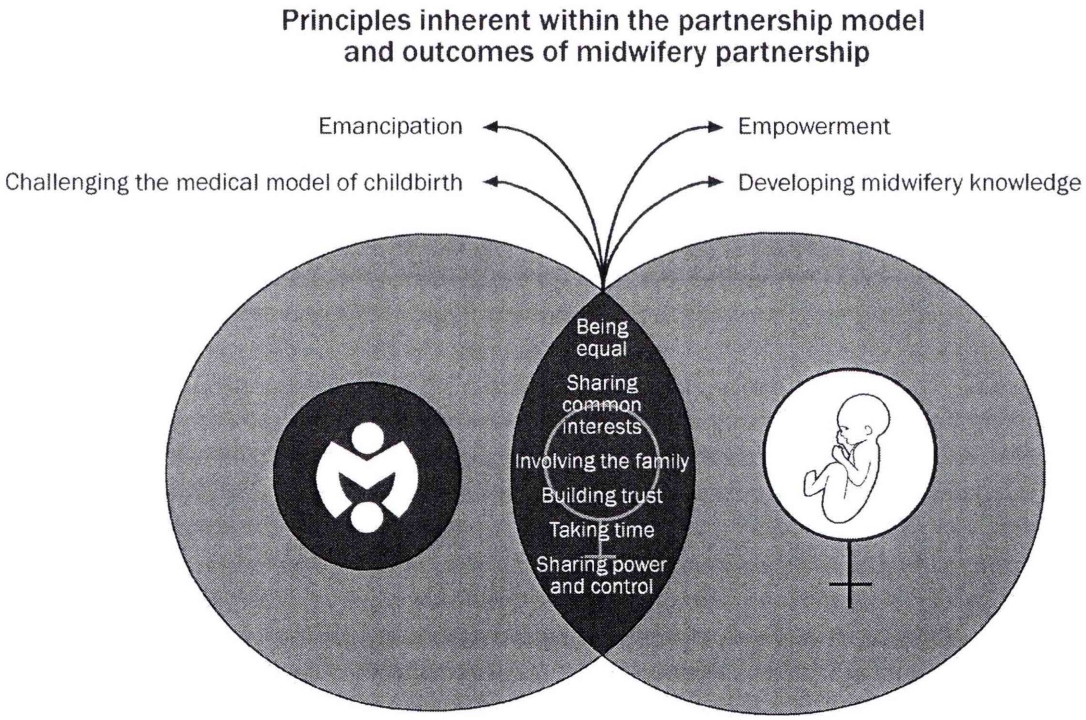
<B>Theoretical Concepts

The philosophical beliefs outlined above provide the conditions within which Midwifery Partnership can form. However, there are also certain principles that must be integrated in the relationship if partnership is to be successfully implemented and

maintained. These concepts are individual negotiation, equality, shared responsibility and empowerment and informed choice and consent (Guilliland and Pairman 1995). These were refined and made more explicit to describe how midwives and women work together. In the refined model the following concepts were identified; being equal, sharing common interests, involving the family, building trust, reciprocity, taking time and sharing power and control. Empowerment, emancipation, developing midwifery knowledge and challenging the medical model of childbirth were identified as potential outcomes of a partnership relationship between a midwife and a woman. (see figure four).

The concepts discussed below are key principles from both models that exemplify the way in which Midwifery Partnership is enacted. In many ways these concepts overlap in their meaning and it is the integration of these concepts that characterise Midwifery Partnerships.

Figure Four: inherent principles in partnership



Principals inherent within the partnership model
and outcomes of midwifery partnership.
(Pairman, 1998)

Source: Pairman, 1998, p.186.

<C>Negotiation

Both partners must participate and contribute if the partnership is to work. Negotiation is the process through which a midwife and a woman work through issues such as mutual rights and responsibilities, the balance of power and decision-making. 'The

underlying premise of the partnership is that it is individually negotiated, recognising the essential contribution of each' (Guilliland and Pairman 1995 p. 44). Negotiation is a process for working things through and coming to mutual understandings and agreements. It relies on open and effective communication and a positive sense of self. Because both partners are different the way in which their relationship is negotiated will be different and each partnership will be unique.

<C>Equality and reciprocity

While differences between partners are recognised and respected, each must feel equal to the other if a partnership is to work. The midwife carries with her the power associated with her professional role and if she is to provide care that the woman finds to be culturally safe the midwife must have examined how this professional power could impact on her midwifery practice. The midwife needs to understand that her professional knowledge and authority can have limited effect if the woman does not contribute her knowledge of herself and her wishes or does not maintain her health or does not work with the midwife. It is important that the midwife recognises and respects the woman as having equal status with an equally valuable contribution. There may be many differences between them but the midwife must take responsibility for acknowledging and respecting those differences.

When a midwife and a woman begin their relationship from a position of mutual respect and equity, their understanding of each other will deepen as they get to know each other. Their relationship is reciprocal in that there is two-way sharing and mutual exchange that creates shared meaning and is beneficial to both.

<C>Trust and time

Trust develops between a midwife and a woman as they get to know each other over time. Trust is essential in any healthy human relationship and in Midwifery Partnership trust underpins information sharing, decision-making, power sharing and empowerment. Trust between two people helps them feel safe with each other and willing to expose their vulnerabilities because they know these will be respected. Faced with the uncertainty of childbirth midwives and women need to trust each other as they also have to trust them selves and trust the process of birth.

> *...She knew that I was scared, she knew how I was feeling. Because we discussed Lauren's birth in detail, and so she knew where I was coming from and I felt very comfortable with her...I trusted her totally* (LF In Pairman 1998 p121).

Trust develops over time and therefore continuity of caregiver enhances the development of trust. So too does visiting women in their own homes where they are comfortable and in control and the midwife can get to know the woman in her own context. As Barrington said;

> *Continuous care, involving generous commitments of time, allows a midwife to gather a store of impressions that will substantiate future intuitions ands actions. Her familiarity with the norms of mother and babe enables her to notice deviations from these norms immediately* (Barrington 1985 p19).

Midwives not only make generous commitments of time through providing continuity of care but also in giving each visit the time necessary for full discussion and

being flexible with appointments so as to meet the woman's needs. Midwives are also accessible to women as required and while women respect midwives' time off it is important that they can access help and advice as necessary. The timing of visits, the place of visits and who to contact for help if the midwife is having time off or is sick are all aspects of the partnership that can be negotiated to suit both partners.

<C>Sharing power and responsibility

In Midwifery Partnerships both partners exercise power and the balance of power is negotiated and mutually agreed. Power is shared through information sharing; through decision-making and through recognising and enhancing each woman's sense of control. Feeling in control during childbirth leads to a sense of satisfaction, fulfilment and positive well being (Green et al 1990). The exercise of power and personal control is dependent upon having resources and options that enable choice, having sufficient information about choices, being able to make decisions and being able to implement those decisions once they are made (Walker, Hall and Thomas 1995).

Midwifery Partnership provides a framework within which a woman can achieve a sense of personal control. In equal and negotiated relationships where both partners trust each other and feel safe midwives can actively support women to exercise their power and make decisions without the midwife imposing her own beliefs. As Dianne described;

> *It was at the back of my mind that she must have her own feelings about what should be done but it never came through. That's what I found really amazing about her, that I never felt in any way that whatever she carried with her (because I believe that anyone who makes a decision – there's a whole lot of other things as to why they make that decision), and I never felt she brought any of that into the situation...she was there but she never moved in* (D McD in Pairman 1998 p.134).

Along with the power to make decisions and be in control comes responsibility for those decisions. While midwives are always professionally accountable for their midwifery judgments and actions, in Midwifery Partnership women also share responsibility for the outcomes of decisions jointly made. As Dianne described taking responsibility and making decisions can be an empowering process:

> *You've got to take responsibility and I think once you take responsibility for your life you can do so much more. It's tied up in a circle – you can evolve much beyond that. It's like taking hold of your life. If you take responsibility then if you get a bad thing out of it them you learn form your mistake. If you get a good thing out of it then you get a real buzz. It's not anyone else's – they might have contributed to it, but it's like 'yeah, I did that and I can take the credit for it'...even today I look at Jessica and I find it really amazing that she grew up in me. I ate really healthy and I felt whatever I did would be reflected in Jessica and I wanted a really good healthy baby...then at the end we got this fantastic little baby who was really alert from day one. Even now she's raring to go. I take a wee credit for that* (D McD in Pairman 1998 p.168).

<C>Empowerment and emancipation

> *For it is in the relationship between women and midwives as they go through the childbearing process together that the message of value and worth is given. It*

cannot be given by strangers mouthing words – it is given by the midwife's commitment to the woman and the process she is involved in (Pelvin 1990 cited in Guilliland and Pairman 1995 p.48).

As this quote from New Zealand midwife, Bronwen Pelvin, exemplifies, Midwifery Partnership can provide the context for both women and midwives to be empowered. Midwifery aims to enable women to recognise their personal power and strengths and to increase women's sense of autonomy and confidence as mothers and women. Because pregnancy and birth are such life changing events they often cause women to ask questions about themselves and their lives and seek to make changes. As Nicky Leap (2000 p.5) said:

The question marks of pregnancy are the beginning of a process of grappling with the uncertainty and decision-making that will persist throughout the experience of raising a child.

Midwives can work with women in ways that facilitate empowerment for woman and this in turn can be empowering for midwives. Key facilitation skills for midwives are believing in women and inspiring confidence, and knowing when to intervene and when to withdraw (Leap 2000). Taking control of their birth experiences may be the first time a woman has controlled anything in her life, and the sense of satisfaction she feels from this may lead to further changes in her life. As Kate commented:

It's a nice feeling to see a woman go from thinking that everyone else own, or has a right to dictate, to deciding – and to see it spill over into other areas is really neat...and start questioning other areas and other things in her life...that's a major plus I think to work with a woman over a longer time (KS in Pairman 1998 p.166).

Although midwives share significant life events with women they are involved in women's lives for only short periods of time in a lifespan. Their involvement with women can be empowering if they work to facilitate independence and self-determination rather than dependence. One way to do this is to encourage women to build their own networks of support rather than relying on midwives who will not be there for the long-term. As Chris explained:

I like to think that the focus is that they're developing their own independence and their own networks to support them, because when you move towards leaving them at six weeks postpartum or whenever, I usually find, not quite that you're rejected, but that you're not needed anymore. By the time you finish they're competent, confident and managing and have set up networks to keep going (CS in Pairman 1998 p.150).

Midwifery Partnership can be empowering for both women and midwives. As midwives work with women through an equal and negotiated relationship their beliefs about birth and about midwifery are reinforced and strengthened. Observing the uniqueness of each woman's birth experience builds midwives' confidence about the ranges of 'normal' that are possible and builds trust in women's bodies. Sharing and negotiating power and decision-making and being able to see the outcomes of these decisions strengthens midwives' trust and confidence in women, and in themselves as autonomous practitioners.

Midwifery Partnership also has emancipatory potential. Women who experience Midwifery Partnership often encourage other women to seek this type of care. *Emancipation is a dynamic state of being in which self-knowledge (enlightenment) and self-advocacy (empowerment) are connected to knowledge and advocacy for others* (Henderson 1995 p.66). As most systems of maternity care in Western societies are still entrenched in the medical model, there is huge scope for women to persuade other women through the telling of their stories about the normalcy of birth and the benefits of one to one midwifery care. As Liz explained:

> *Your relationship with your midwife is amazing. Everyone I've spoken to since I've just been raving to about it. Hopefully I'm spreading the word...it's a shame some people just don't have the confidence in midwives or themselves or aren't aware of that 'oh no, we must have a doctor scenario'...I personally can't see any other option now...I just can't see the advantages of doing it in any other way...I'm sold, I'm sold* (LG in Pairman 1998 p.171).

New Zealand and Canada provide two examples of where political action by women has led to significant structural and philosophical changes in the way that maternity services are delivered and developments of more women-centred models of care.

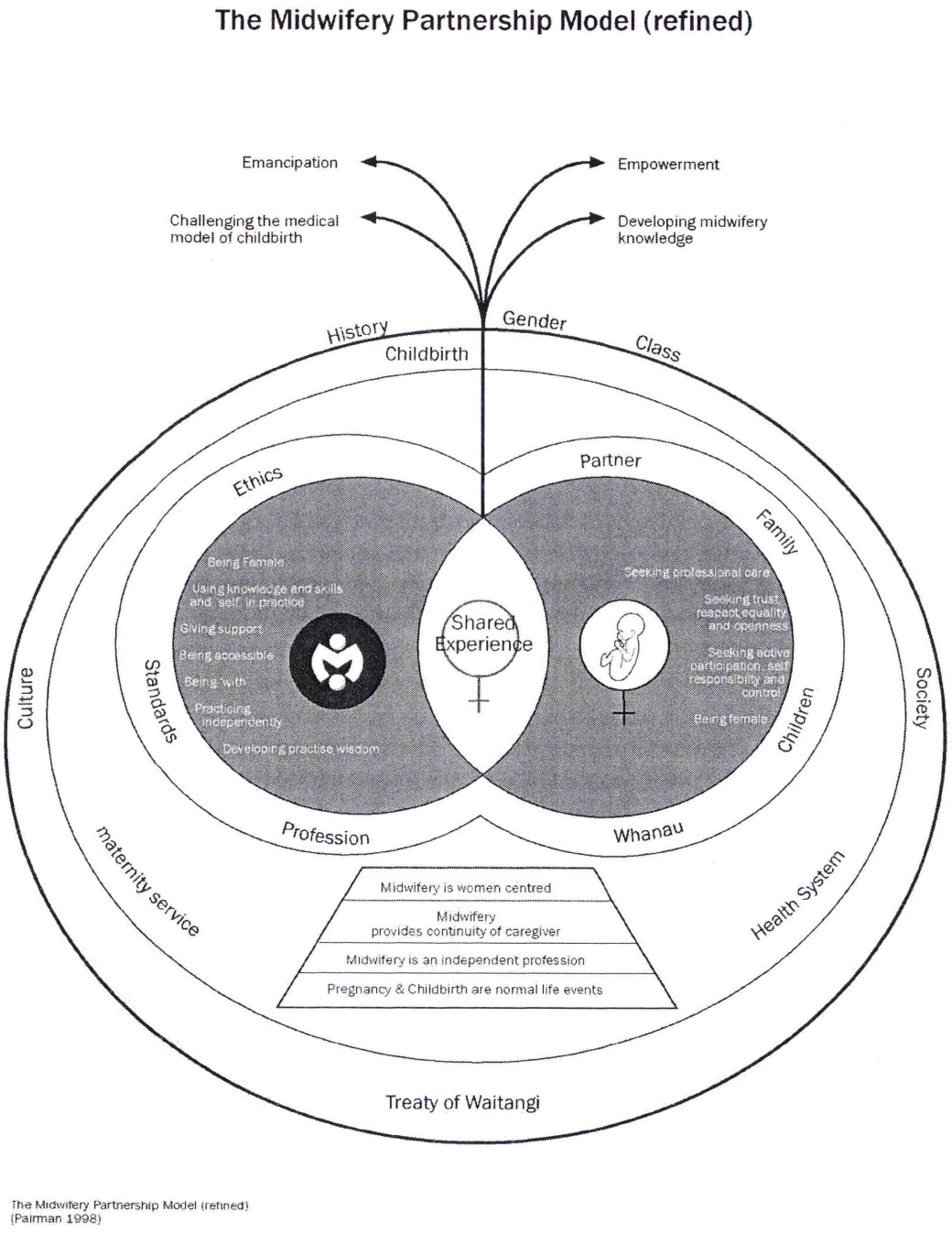
<C>Professional friendship

The participants in my study teased out Midwifery Partnership to mean 'professional friendship' (Pairman 1998). The term 'professional friend' described for them the friendship aspect of the relationship between women and midwives but also recognised the professional nature of the relationship and its time limited nature. As Bizz explained:

> *I think we had a really good relationship actually. It was more of a friend relationship, but a friend you could trust in – a professional friend you could rely on* (BF in Pairman 1998 p.163).

The refinements to the partnership model (see figure five below) as suggested from this study provided further depth and understanding of the concepts by exploring how women and midwives experienced midwifery partnerships. Further exploration of the notion of professional friendship will contribute to midwifery's understanding of the practice of partnership.

Figure five: the refined model of Midwifery Partnership



The Midwifery Partnership Model (refined)
(Pairman 1998)

Source: Pairman, 1998, p.190

<A>The importance of partnership to midwifery

Without partnership midwifery would be just another professional/client relationship where the midwife holds authority as the 'expert' and wields this authority and power through clinical decision-making. The client in this relationship may not disclose her own fears or expectations or ask questions because the power base is such that she may feel intimidated or unwilling to disturb her perception of the correct way to behave to the midwife.

This type of health professional relationship will be familiar to many. Midwives who work in the hospital system of shift work are unlikely to know the women they care for. They are kind and concerned for these women and try their best to provide them with good care. But they don't know the women and women don't know them. If women have birth plans or if they are asked, midwives may be aware of some of their wishes for birth. Very often though the routine of the hospital dominates and women receive a similar level of care no matter what their individual needs or wishes.

The context of hospital maternity services very often constrains midwifery care through fragmentation of care, insufficient staffing numbers, hierarchies and organisational control. Such settings can undermine midwifery knowledge, confidence and trust, making it difficult for women midwives to support women to take control of their birthing experiences (Kirkham 2000b).

A partnership relationship on the other hand, allows a midwife and a pregnant woman to *get to* know and trust each other over time. As the midwife and the woman see each other as individuals and understand each others' perspectives they are able to negotiate how they will work together to meet the woman's needs while still respecting the midwife's professional boundaries. Through this negotiation the power balance shifts and equalises.

To work in this way requires self-knowledge, personal security, integrity and maturity. The midwife can no longer rely on her professional role as 'expert' to guide her practice. Instead she must open herself as a person to each woman she works with and be willing to recognise and embrace each woman as an equal partner as together they explore the physical, emotional, social and spiritual ramifications of childbirth for that woman. The midwife brings her midwifery knowledge and understandings to the relationship, as the woman brings her knowledge and experiences. But rather than directing care the midwife works 'with' the woman to support her to take up her power as a woman and as a mother so that she can direct and control her own birthing experience and feel confident in her new role as a mother.

When midwifery is practised independently and in partnership with women it has potential to not only enhance women's (and midwives') empowerment and emancipation, but also to contribute to the reframing of childbirth as a normal life event, to build midwifery knowledge and understandings and to challenge the medical dominance of childbirth. By redefining professional relationships from midwife as 'expert' to relationships where women are partners in their care, midwives and women can create contexts in which women-centred care can flourish.

When midwives and women work together in partnerships with a political imperative changes can be made to maternity services and the choices for care that are available to women. Midwifery Partnership provides a model for the development of political partnerships between maternity consumer groups and midwifery professional organisations. As seen in New Zealand these partnerships can be a force for social change. Successful implementation of small changes such as establishing one-to-one care in a single maternity unit can lead to further developments as more women demand this type of care and more midwives demand to work in this way.

However, partnership, like autonomy and independence, also carries responsibility. When New Zealand women took political action to achieve midwifery autonomy they did so because they believed that midwives would provide them with an alternative model of maternity care in which women would be in control as decision makers. Therefore midwives had a moral obligation to provide the kind of care and relationships that women sought. Partnership also carries a moral obligation for midwives to recognise and respect individual differences in women and to provide care that meets these individual needs.

Midwives in any country and in any cultural context work with childbearing women who are different to them. Midwives need to examine their relationships with childbearing women because these relationships are at the heart of midwifery practice. Midwifery Partnership provides a framework for achieving meaningful relationships between midwives and women whereby women are active agents in their care.

Working in partnership is demanding. It requires self-knowledge, strong and effective communications skills and a secure sense of self on the part of midwives. It takes trust, time and the ability to be reflective. Like any human relationship it will change and evolve and at times both partners may feel uncertain and insecure. Each new relationship with a woman will add to a midwife's understanding of herself and how she works with women if she is willing to examine these.

The model of midwifery partnership provides guidance to midwives wanting to develop partnerships with women and the concepts discussed above are a starting place for reflective practice and learning about working in partnership.

<A>Conclusion

Midwifery must be concerned with relationships because, unlike any other health profession, midwifery is privileged to have the opportunity to be 'with' women throughout the life experiences of pregnancy, birth and new motherhood. In their professional roles midwives are able to develop relationships with women that last up to 10 months (sometimes longer) and they have the opportunity to work with women in their own homes and communities, away from the influence and control of institutions. In such settings the traditional practitioner/patient relationship where the practitioner is the 'expert' and has the authority to make decisions is clearly inappropriate. Midwives who work in continuity of care models work in contexts in which relationships are valued and where midwifery care such as support, caring and enabling is recognised as skilled midwifery practice. Midwives and childbearing women in these settings need to develop relationships of equity, trust and

mutual understanding. So too do midwives and women working within the constraints of hospital services where the context is generally much more challenging and unsupportive to the development of partnership relationships between midwives and women.

However, the potential for empowerment of women through their childbirth experiences cannot be overlooked. Nor can the need to reframe childbirth away from the medical model perspective to recognition that childbirth is a normal life process that generally requires support rather than intervention. For these important processes to be achieved women must be in control of their own birthing experiences and supported to make decisions for themselves. Women who feel empowered during childbirth will take that confidence with them as new mothers and this in turn will strengthen their families and society. The ripple effects of positive birthing experiences are far reaching and cannot be underestimated.

Midwifery Partnership provides a framework for a new way for midwives and women to work together – one that is meaningful and mutually beneficial to both. Midwifery Partnership challenges professional power structures and medical dominance over childbirth through recognising birthing women as active partners of equal status in the shared experience of maternity care.

Midwifery Partnership provides a framework for achieving long-lasting social change in developing women-centred and midwife-led maternity services.

References

Association of Radical Midwives. (1986) *The Vision: proposals for the future of the maternity services.* ARM, London

Australian Nursing and Midwifery Council. (2005) *Role, Scope of Practice and Development of National Competency Standards for Midwives.* Online. Available https://www.anmc.org.au/ 31 March 2005

Barrington E (1985) *Midwifery is catching.* Toronto, NC Press Ltd.

Crabtree, S. (2004) Midwives constructing normal birth. In S Downe (ed) *Normal childbirth: evidence and debate.* Churchill Livingstone, London.

Dobbie M (1990) *The trouble with women. The story of Parents Centre New Zealand.* Cape Cately Ltd, Whatamongo Bay.

Donley, J. 1986, *Save the Midwife,* New Women's Press, Auckland.

Donley, J. (1989). Professionalism. The importance of consumer control over childbirth. *New Zealand College of Midwives Journal,* September, 6 – 7.

Downe, S. (2004) Aspects of a controversy: summary and debate. In S Downe (ed) *Normal childbirth: evidence and debate.* Churchill Livingstone, London.

Downe, S & McCourt, C. (2004) From being to becoming: reconstructing childbirth knowledges. In S Downe (ed) *Normal childbirth: evidence and debate.* Churchill Livingstone, London.

.....Cartwright S (1988) *Report of the Cervical Cancer Inquiry.* Government Printing Office, Auckland.

Flint, C. (1986) *Sensitive midwifery,* Heinemann Midwifery, London.

Green, J, Coupland, V Kitzinger, J (1990) Expectations, experiences and psychological outcomes of childbirth: a prospective study of 825 women. *Birth, 17,* 15 – 24.

Guilliland, K. 1989, 'Maintaining the links – a history of the formation of the NZCOM', *New Zealand College of Midwives Journal,* September, pp.14-15.

.....Guilliland, K. & Pairman, S. (1995). *The Midwifery Partnership: a model for practice.* Monograph series: 95/1, Department of Nursing and Midwifery, Victoria University of Wellington, New Zealand.

Henderson, D. (1995) Consciousness raising in participatory research: method and methodology for emancipatory inquiry. *Advanced Nursing Science, 17,* (30, 58-69.

Houd, S. (1993) The spirit of midwifery. Keynote address, proceedings of the International Confederation of Midwives, 23rd International Congress, Vancouver, May, 75-86.

.....Hunt S & Symonds A (1995) *The social meaning of midwifery.* MacMillan, London.

International Confederation of Midwives. (1990) Definition of a midwife. *Position Statement 90/1,* ICM, London

Katz Rothman, B. (1984). Childbirth management and medical monopoly: midwifery as (almost) a profession. *Journal of Nurse-Midwifery, 29,* (5), 300 – 306.

.....Kirkham M (1996) Professionalisation past and present: with women or with the powers that be? In D Kroll (Ed) *Midwifery care for the future. Meeting the challenge,* Bailliere Tindall, London, 164-201.

Kirkham, M. (Ed) (2000a). *The midwife-mother relationship,* Macmillan Press Ltd, London.

Kirkham, M. (2000b) How can we relate? In M. Kirkham (ed), *The midwife-mother relationship,* Macmillan Press Ltd, London.

Leap N (2000) The less we do the more we give. In M Kirkham (Ed) *The midwife-mother relationship* Macmillan Press Ltd, London, 1-17.

Leininger M (1991) *Culture Care Diversity and Universality: A theory of nursing.* New York, National League for Nursing Press.

.....McCrea H & Crute V (1991) Midwife/client relationships: midwives' perspectives. *Midwifery, 7,* 183-192.

McIntosh, P. (1988). *White Privilege: Unpacking the Invisible Knapsack.* Retrieved 8/8/2004 from http:// www.utoronto.ca/acc/events/peggy1

Midwives Alliance of North America. (1991) *MANA Core Competencies for basic midwifery practice,* MANA, Bristol, VA.

Midwifery Council of New Zealand (2004) *Midwifery Scope of Practice.* Online. Available http://www.midwiferycouncil.org.nz/main/Scope/ 31 March 2005

New Zealand Health Information Service (2004) *Report on maternity 2002. Maternal and newborn information.* Ministry of Health, Wellington.

Ministry of Women's Affairs (1989) *Women's health: what needs to change.* Author, Wellington.

New Zealand College of Midwives (1993). Midwives handbook for practice. NZCOM, Christchurch.

New Zealand College of Midwives (2005). Midwives handbook for practice. NZCOM, Christchurch.

Nursing Council of New Zealand. (2002). *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori health in nursing and midwifery education and practice.* NCNZ, Wellington.

Nursing Council of New Zealand (2004) *New Zealand registered nurses, midwives and enrolled nurses. Workforce statistics 2002.* Author, Wellington.

.....Page L (1993) Redefining the midwife's role: changes needed in practice. *British Journal of Midwifery, May, (1), 21-24.*

Page, L.A. (1998) The midwife's role in modern healthcare. In S. Kitzinger (ed) *The midwife challenge,* Pandora Press, London.

.....Parkes C (1993) The impact of medicalisation of New Zealand's maternity services on women's experience of childbirth 1904 – 1937. In L Bryder (Ed) *A healthy country. Essays on the social history of medicine in New Zealand.* Bridget Williams Books, Auckland.

Pairman, S. (1998). *The Midwifery partnership: an exploration of the midwife/woman relationship.* Unpublished Master's thesis, Victoria University of Wellington.

Pairman, S. (2000) Women-centred midwifery: partnerships or professional friendships? In. M. Kirkham (Ed) *The midwife-mother relationship,* Macmillan Press Ltd, 207 – 226.

Pairman S & Guilliland K (2003) Developing a midwife-led maternity service: the New Zealand experience. In M. Kirkham (Ed) *Birth Centres: a social model for maternity care.* Books for Midwives, London.

Pairman, S. & Donnellan-Fernandez, R. (in press). Professional frameworks for practice in Australia and New Zealand in S. Pairman, J. Pincombe, C. Thorogood & S. Tracy (Eds) *Midwifery: Preparation for Practice.* Elsevier Churchill Livingston, Sydney.

.....Pelvin B (1990) Midwifery: the feminist profession. *Proceedings of new Zealand College of Midwives first national conference, Dunedin,* August.

.....Pelvin B (1992) Current ethical considerations. *New Zealand College of Midwives Journal,* December, 6-9.

Powell Kennedy H (1995). The essence of nurse-midwifery care: the woman's story. *Journal of Nurse-Midwifery, 40,* (5), 410-417.

Ramsden, I. (1990) *Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa.* Ministry of Education, Wellington.

Ramsden, I. (2000). Cultural safety / Kawa whakaruruhau ten years on: a personal overview. *Nursing Praxis in New Zealand, 15*(1), 4 –12.

Ramsden, I. (2002) *Cultural safety and nursing education in Aotearoa and Te Waipounamu.* Unpublished PhD thesis, Victoria University of Wellington.

Richardson, F. (2000). *What is it like to teach cultural safety in a New Zealand nursing education programme?* Unpublished thesis presented in partial fulfilment of the requirements for the Degree of Masters of Arts. Massey University: Palmerston North.

.....Sandall J (1995) Choice, continuity and control: changing midwifery towards a sociological perspective. *Midwifery, 11,* 201-209.

Spence, D. (2004). Prejudice, Paradox and Possibility: The Experience of Nursing People from Cultures other than One's Own. In Kavanagh, K, H., & Knowlden, V (Ed), *Many Voices, Toward Caring Culture in Healthcare and Healing* (pp. 140-180). Wisconsin: The University of Wisconsin Press.

Strid, J. 1987, 'Maternity in revolt', *Broadsheet, 153,* 14-17.

..... Tully E. 1999. Doing professionalism differently: negotiating midwifery autonomy in Aotearoa/New Zealand. Unpublished doctoral thesis, University of Canterbury, New Zealand.

Walker, J, Hall, S & Thomas, M (1995). The experience of labour: a perspective from those receiving care in a midwife-led unit. *Midwifery, 11,* 120 – 129.

Pairman. S. & Guilliland, K. (forthcoming). The Midwifery Partnership Model: ten years on. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

[Note this is an unedited version prior to publication and may be altered in the editing process]

Chapter six: The Midwifery Partnership Model: ten years on

> *"The challenge for women and midwives is to sustain the momentum of partnership and bring about long lasting and meaningful social change which continues to value women's status and experiences within the childbearing continuum"*
> (Guilliland and Pairman, 1995, p. 51.)

Introduction

New Zealand midwifery practice is based on the theoretical constructs of partnership. The framework for partnership was written by us in 1994 as part of our master's study and published in a monograph in 1995 by Victoria University of Wellington. At that time the concept of partnership struck a chord, not only with New Zealand midwives but also with colleagues elsewhere in the world. Murray Enkin, Professor Emeritus, Department of Obstetrics and Gynaecology, Clinical Epidemiology and Biostatistics, McMaster University, Ontario, Canada and one of the founders of the Cochrane Collaboration had this to say about the model:

> *"The monograph is beautiful. Indeed, I would consider it unique. The concept of a true sharing of all information with the non-professional member(s) of the relationship upsets all the traditional concepts of a profession, in which power is maintained by the jealously guarded expertise of the professional.*
> *The midwifery partnership is not only a model for practice, it can serve as a model for profession: client relationships in all fields. Would that its example were to be widely emulated."*
> (Enkin, 1995, personal correspondence).

In this chapter we intend to discuss what we thought about midwifery partnership in 1994 and why we wrote the model the way we did. We will then examine how the practice of partnership has become established in midwifery over the intervening years. Finally we will re-examine the partnership model in the context of today's midwifery practice.

Why we wrote it

When we wrote the monograph "The Midwifery Partnership: a model for practice' in 1994, midwifery autonomy was only four years old (Guilliland & Pairman, 1995). It was the Nurse's Amendment Act of 1990 that enabled midwifery autonomy and created the possibility of new ways of working. By removing the requirement for doctors to supervise

midwives in practice, the Act allowed midwives to take full responsibility for the midwifery service they provided and how they delivered it. The Act also established an alternative mechanism for midwives to be paid that did not require them to be employed. It was this ability to be independent, both professionally and financially, that influenced the speed and sustainability of the move to midwifery-led care in New Zealand. Historically the majority of midwives had been employed by hospitals. The new legislation gave midwives the same ability to claim from government maternity benefits as doctors, and therefore they were able to set up practice as self-employed practitioners in the community, providing care to their own caseload of women.

Given that the status quo was that midwives worked in hospitals providing primary, secondary, and tertiary care, the move to community-based care required midwifery to refocus on the provision of primary maternity care for well and healthy women. Indeed the College's submission on the Nurses Amendment Act had focused on midwifery as primary health care and the possibilities this offered to women and their families (NZCOM, 1989). In the prevailing hospital services of the day both midwives and women experienced a fragmented maternity service that was primarily designed to meet the needs of the organisation rather than those of the women who used it. Neither did the structure recognise midwifery as a profession nor that an individual midwife could provide a total service throughout the childbirth continuum. Providing a community-based primary maternity service meant that midwives could now attend the same women throughout antenatal, labour, and birth and the postnatal period. That is, midwives could provide a midwifery model of care and utilise the full scope of midwifery competencies. This meant the hospital was no longer the only location for services and the provision of antenatal and postnatal care in women's homes increased, as did homebirths.

For those midwives, in the early 1990s, who actively chose to take up this opportunity for having their own caseload of women, and who were now working in women's homes and getting to know them and their families over a longer period of time, the whole culture and environment in which they practised changed significantly. Not surprisingly it also changed the way these midwives saw themselves as professionals. The speed and uptake of these practice changes was exciting and we wanted to record and describe what was happening. Our focus was on these midwives and the way they practised because they were reclaiming midwifery traditions. We believed that if women experienced an alternative midwifery service to the hospitalised and medicalised model of the last decades that they would be in a better position to make choices about how they had their babies and in turn demand changes to the way in which mainstream maternity services were provided. We were also conscious that women had fought for the legislative changes of 1990 in order to access this type of midwifery care and we believed that the midwifery profession now had a moral obligation to promote and support midwives to practise in this way. Therefore it was necessary to concentrate on the possibilities for midwifery autonomy that the Nurses Amendment Act had enabled. We saw these early independent midwives as modeling a way of working that other midwives could emulate and we hoped that our descriptions would encourage midwives to support women who wanted full midwifery care. We had seen that the experience of both giving and receiving full midwifery care was in itself a way of changing midwives' and women's understandings of birth. We also thought it would encourage normal birth.

Another impetus for writing about this alternative model of midwifery care was to articulate for midwifery what it was that distinguished it from nursing. The profession believed that the main point of difference was midwifery's ability to provide continuity of care throughout the maternity experience on its own responsibility. No other profession did that. Medicine relied on midwifery for labour, birth, and postnatal support services and nursing was legally only able to provide maternity care under the supervision of doctors and midwives. Given that the vast majority of midwives at that time had not practised in a continuity of care model, our purpose was to provide a description that would help them understand this alternative form of practice.

The context of the partnership model of 1994

For most midwives in the 1980s and early 1990s the hospital was 'home'. For most it was familiar, and if not always particularly comfortable it was safe, bound by known protocols and routines that controlled both the midwives and the women with whom they worked. Leaving the security of the hospital environment was too great a challenge for the majority of midwives. However, for the small percentage that did in the early 1990s, working with women in their own homes was a positive experience. It showed midwives a different way of being with women. It also helped midwives recognise the impact that the hospital environment had had on their view of birth and their midwifery practice. Midwives began to question many of their previously taken for granted assumptions about the way in which women experienced pregnancy and childbirth, the way in which maternity services were organised and the routines of midwifery practice. They also started to examine their midwifery role and what it meant to be a member of a profession. They started to see themselves more "with women" than as an expert authority.

In a one-to-one long-term relationship with a woman in her own home the midwife was exposed to different power dynamics. Previously within the hospital setting the midwife was defined as part of the obstetric team that was led by the doctor. Collectively both the team and the institution were given an authority that carried with it the status of 'expert' and 'decision maker'. Once midwives were independent from the hospital and the team this authoritative expert role was not appropriate in the home setting where it was the women and families who were in familiar territory and in control. As a result, midwives needed (and wanted) to engage in relationships that were more equal and reciprocal.

Midwives and midwifery embraced this new environment. Now midwives could fully engage in ongoing relationships 'woman to woman', sharing their midwifery knowledge and expertise with women who brought their own acknowledged expertise and expectations to the relationships. With shared knowledge and information, came shared power and decision-making. It also increased midwives' awareness of their personal and professional responsibilities and accountabilities. Responsibility was more transparent and individually owned since the midwife and the woman had come to decisions together. They had started to experience working as partners.

The midwifery profession had articulated midwifery as a partnership as far back as 1989 in recognition of the political partnership between women and midwives that brought about

the 1990 legislation. After 1990 as midwives and women were able to work together differently, they increasingly described this practice relationship as a partnership.

The writing up of the midwifery partnership model in 1994/5 provided a description of the relationship that we observed between midwives and women in this changing environment. Its purpose was not only to articulate and record how midwifery practice developed during this time but also to provide a framework for practice for the future (Guilliland & Pairman, 1995). The future we saw at that time was that all women regardless of "risk factors" would eventually know their own midwife and that midwifery services would be structured in a way to facilitate this. The main difference we saw for women receiving primary midwifery services as compared with secondary maternity services was the level of consultation and collaboration required by midwives with obstetrics and other medical specialties. This was not to imply that midwives would provide secondary services as the Lead Maternity Carer, but rather that all women regardless of their health status required midwifery care and that this should ideally be provided in a continuity of care model.

We thought that self-employed midwives in the community would provide continuity for the majority of women who experienced normal birth. Those women who required obstetric assistance would receive midwifery and medical care from employed staff within the secondary and tertiary maternity facilities. The aim was to extend continuity of care into the maternity facilities to include midwives looking after women with secondary care conditions so that eventually all midwives would provide continuity of care to a caseload of women and that facilities would enable this to happen. We thought that continuity of care teams in base hospitals would provide continuity services for women requiring secondary care in collaboration with obstetricians leading the team. Therefore every woman, whether in primary or secondary care, would eventually have her own named midwife. We did not focus on the role of the hospital midwife outside of the continuity of care model because we thought that their numbers would be few if the continuity model was available to all women in New Zealand.

However, continuity of care for all women did not evolve in the way that we envisaged with very few hospitals establishing the model for women with secondary and tertiary needs. As explained in chapter X on funding it was the community-based self-employed midwives who increasingly provided continuity for these women. As a result the role of the hospital midwife has actually become more pivotal in supporting the interface between primary, secondary and tertiary maternity services than we anticipated at the time. We will discuss this development later.

We anticipated that the practice of partnership as described in the monograph would evolve into mainstream practice as more midwives worked in this way. We expected that this evolution would be gradual and that the choices made by individual midwives and women around models of care would drive the pace of this change.

In the event midwifery practice and midwifery relationships had little opportunity to evolve at their own pace as they were overtaken by a variety of external changes not under midwifery's control. These included at least three major restructurings of the health system within a period of ten years (Gauld, 2001), with accompanying changes to funding

mechanisms, development of the obstetric referral guidelines (Ministry of Health, 2002), the withdrawal of general practitioners from maternity services, the rise of medical specialties and the global increase in the use of technology in childbirth. Each and every one of these episodes impacted significantly on the maternity service, the context of midwifery practice, and the development of midwifery partnership as a model of care. These contextual issues are discussed more fully in chapter X on funding.

The evolution of partnership from 1994 to 2005

As explained in chapter X on funding, the Health Funding Authority's development of the Lead Maternity Caregiver Service Specifications in 1996 changed the shape of midwifery as significantly as the Nurses Amendment Act had done in 1990. Its emphasis on all women having a Lead Maternity Caregiver (LMC) and continuity of care as the cornerstone of the maternity service was revolutionary. It placed women in the centre of the service and provided a new context in which midwives could practice autonomously and where partnership between the woman and the midwife could flourish.

Midwifery LMC numbers increased as many midwives left their hospital employment to establish self-employed practices in the community. The LMC framework gave these midwives an opportunity to fully explore and develop partnership relationships with women. However, the midwives who remained employed in hospitals had fewer opportunities to make these same explorations. Their roles changed in response to the new LMC midwife role and tensions between midwives were inevitable. It has taken some years for the profession and individual midwives to resolve these issues.

The LMC model coincided with the introduction of the Code of Rights for health consumers. The 1996 Health and Disability Code of Rights enshrined informed consent as a statutory right. Under the 1996 Section 51 Maternity Notice (Ministry of Health 2002) women were expected to choose their own midwife or general practitioner or obstetrician, and in line with the Code of Rights, to make decisions about all aspects of their care. These two pieces of legislation together provided a women-centred framework for practice that closely fitted midwifery's philosophy of partnership. The previous routine delivery of maternity care changed markedly and all maternity providers, including midwives, had to adapt their practice to meet both the service specifications outlined in Section 51 (later Section 88) and their obligations under the Code of Rights.

Over the intervening years partnership as a form of midwifery practice has been taken up not only by New Zealand midwives but also internationally, particularly in relation to midwifery education curricula. New Zealand midwives have used the partnership model as a guide and have explored and adapted the concepts within their day-to-day practice. The New Zealand midwifery profession has embedded the concept of partnership into its professional framework. New Zealand still stands as the only country to have embedded partnership in all aspects of the profession including the professional organisation.

While the profession had identified partnership as a standard for practice, a philosophy and an ethical stance, the model as articulated in the monograph was the first attempt to document and tease out the components of the relationship to help those early autonomous midwives make sense of the system they were working in and the new kind of professional

relationships they were able to experience. Now, in 2005, partnership has become mainstream midwifery practice and it is timely to explore again the ways in which midwives have adapted their practice to incorporate partnership, whether working as caseload midwives, core midwives, midwifery educators or midwife managers.

Revisiting the model

While the model can be enhanced through more explanation, we believe that the basic principles and concepts remain intact. Other researchers have also provided support to the partnership model and a deeper understanding of the way in which women and midwives experience partnership. Interestingly in many different parts of the world where midwives are able to establish relationships with women throughout the maternity cycle, the same or similar concepts and understandings have been identified and explored (Kennedy, 1995; 2002, 2004; Walsh, 1999; Harding, 2000; Kirkham, 2000; Page 2003).

We have strengthened our understanding of the practice of partnership as a result of watching the different ways midwives and women make partnership work for them. In observing each other's practice of partnership midwives have raised questions about the application of the model to particular practice contexts. Rather than trying to change the model to suit every individual style of midwifery practice, the College of Midwives in particular, has tried to encourage midwives to accept the principles inherent in partnership. It is up to each midwife and each woman to decide how they want their relationship to look; in other words to work in partnership. Thus the model can be used as an impetus for change in practice.

Partnership is not an absolute. It is not something that everyone (both women and midwives) can do or will do or even wants to do in every instance. But it is a model that the vast majority of women and midwives can identify with, adapt and modify and use successfully. It is a framework for practice. Like all frameworks it rises and falls on the way in which it is understood and the way in which it is implemented. Like all relationships the midwife/woman partnership is by definition dynamic and changing depending on the partners involved.

Having said this, midwives are charged with establishing relationships with women and the development of a partnership relationship is an active professional role for midwives. Therefore we have identified some aspects of the model that require fuller exploration in order to assist midwives to incorporate partnership into their practice.

Midwifery and partnership

Midwifery ***is*** a partnership. ***Partnership*** is a relationship. A midwifery partnership is a relationship between a woman and her midwife. Like all relationships, a midwifery partnership is defined within the context in which it is experienced. For women and midwives this context is the experience of pregnancy and childbirth. Given that pregnancy and childbirth are normal life processes, most women should be able to expect that their birth experience will be physiological and uncomplicated. They should also be able to expect a healthy and straightforward relationship with their birth attendant.

This expectation of normalcy defines the primary role of the midwife as one who supports and protects this normal life process. However, the need for the presence of a midwife also implies that this normal process can go wrong at times. Herein lays the tension for midwives, as they balance their role as supporters and guardians of 'normal' with their role in ensuring safety when complications arise. Assuming that a normal process will unfold, and working actively to assist this, while at the same time continually watching for signs that the process is not progressing normally, requires complex midwifery skills. It requires well-developed assessment skills and a broad scientific and artful knowledge base combined with the ability to make judgments and act on these quickly. For midwives to achieve this relies most of all on their relationship with the woman.

Feelings and experiences are what relationships are made up of. In childbirth love and fear are the two strongest feelings for both a woman and a midwife and yet often go unrecognized and without acknowledgement. Recognizing and balancing these two extreme emotions is the day-to-day work of a midwife. The way in which she balances them is the art and science of midwifery. A strong two-way relationship between a woman and a midwife in which they share each other's knowledge, feelings, experiences and skills, enables both to make sound decisions.

Belief in normal birth

Pregnancy and childbirth are fundamental life events. While the process is physiological, the way in which society views and treats childbirth is socially, politically and culturally constructed. Because of the importance placed on birth by all societies, midwifery will always be influenced and affected by the values and belief systems of the society in which it exists. Midwifery around the world shares a philosophy in which childbirth is constructed as normal. Conversely obstetrics constructs pregnancy and birth as an illness requiring monitoring and intervention to ensure a safe outcome. Today New Zealand midwifery sees itself as a transformative profession that has a role in expanding women's beliefs in themselves and in encouraging self-determination and control over their normal body processes. It has used the human right principle of equality to work for improvement in the position of women in society in relation to childbirth services.

Equality

New Zealand midwifery has also positioned itself as a profession that is equal to others. Equality has its roots in the woman's health movement and is a political and social platform for empowerment of both women as birthing mothers and midwives as professional women. The framework in which midwifery tries to achieve equality is that of partnership.

When we describe midwifery as a partnership, we are describing normal healthy balanced relationships between women and midwives. In normal healthy relationships both partners listen to each other, communicate openly, negotiate differences, and arrive at common understandings. The underlying principle that governs a successful relationship is that both partners respect each other as equal persons in their own right. This does not imply that they are the same, only that they both value each other and that both have rights within the relationship. To achieve the sense of equality between the midwife and the woman requires an understanding of the power dynamic present between health professional and client.

An underlying principle of midwifery partnership is empowerment. Power in its simplest sense is the ability to do or act or have under one's control. It can also mean authority or personal ascendancy over another person or thing (Oxford Dictionary, 1963). Empowerment is a process of enablement in which both partners support each other to exercise their personal power without undue authority or personal ascendancy over the other. Like equality, power is an intangible dynamic that is difficult to measure but its absence or presence can be felt and internalized by individuals regardless of their ability to articulate it.

In traditional professional relationships the health professional exercises power over the patient (client) on the basis of their superior knowledge and expertise. It is assumed the patient/client will follow the directions of the health professional because of their expertise in any given subject. In the midwifery partnership, on the other hand, the notion of the midwife as the only 'expert' is rejected. Instead, both the midwife and the woman are recognized as having their own expertise, which is shared to the benefit of both. In this way both partners exercise power. Both actively contribute to the relationship and both participate in negotiating how the relationship will work. This is the exercise of power. While the balance of power may fluctuate over the course of the relationship, both partners understand and negotiate this. For example, there may be times when the woman needs the midwife to take the lead, such as when the woman is in labour. At other times the midwife may need to pull back and resume her support role, such as when the woman is gaining confidence in breastfeeding her baby. In an uncomplicated physiological pregnancy and birth the midwife and the woman share power as agreed between them. Often this is not articulated, but is worked through over time in the process of getting to know each other, understanding and trusting each other and discussing the woman's expectations and wishes.

In a complicated pregnancy a woman can often feel powerless in the face of unexpected developments, particularly if the woman or her baby is very unwell. The woman then relies more on the midwife's knowledge and skills to help her understand and maintain or regain her sense of control. At the same time midwives will need to act effectively in emergency situations. The midwife needs to feel confident in her own personal and professional authority to make decisions that will keep the woman and her baby safe. After all, women seek midwifery care not only for education and support, but also with the expectation and confidence that the midwife will make appropriate professional judgments and act on these when necessary. This is not an abuse of power because it comes out of mutual understandings gained through a relationship where information is shared.

Informed decision making

In a normal healthy partnership the woman has had time to understand the role and scope of practice of a midwife, which includes making midwifery judgments and acting on these as appropriate. Sometimes there is confusion between a midwife's decision-making power and the process of informed consent. Informed consent should not be used as an excuse for not making a midwifery judgement. While the woman should be informed about why a midwife is making a decision and it is true that most decisions do rest with the woman, midwives have to be clear about the way in which they offer information and the occasions on which midwives offer women a 'choice'. For example there is overwhelming evidence that giving women Pethidine in labour for relief of pain is ineffective and on some

occasions even detrimental to the woman and her baby, and yet some midwives continue to offer it routinely as if it is a real 'choice' that will always relieve pain. When there is clear evidence that an action is detrimental to a woman or baby the midwife should offer unequivocal advice. For example, advice on suturing of the perineum, the administration of an oxytocic when the woman is bleeding or the administration of oxygen to a compromised baby and giving Pethidine in labour for pain relief. On most occasions the woman will confidently accept the advice and the intervention because she trusts the midwife's judgement. On the very few occasions when the woman refuses treatment, there are clear guidelines for documenting why the midwife did not act on her professional judgement.

Reciprocity

Midwives and women bring different contributions to their relationships and both contributions are necessary. The relationship is reciprocal in that knowledge is shared, power is shared, decisions are shared, and responsibilities are shared. Because the relationship is negotiated it will work the way the two individual partners want it to work. There is no one right way to be 'in partnership' or to be a midwife, or one way in which all relationships will evolve.

Most normal healthy relationships require time to get to know each other and to build trust and understanding between the partners. So too does the midwifery partnership and therefore continuity of care is an important foundation to the context of the relationship. This is not to say that midwives cannot have positive and healthy relationships with woman that they do not know, such as women they meet for the first time in labour, but midwives must recognize the relationship *will* be different to one where they get to know the woman well over time. Because the relationship is different, the balance of power, the level of trust and shared understandings will not have been articulated and negotiated. For example, pregnant women may trust midwives simply because they are health professionals or because they are health professionals working in a context that the woman trusts, such as a hospital. In these situations there may be an even greater obligation on the part of the midwife to ensure that this trust is not misplaced. The sense of responsibility for midwives in these situations cannot be underestimated. Without the luxury of time to build a relationship decision-making will take a different form. Informed consent becomes a leap of faith on the part of the woman, rather than a considered decision arrived at over time. On the other hand, where the woman and the midwife know each other well, trust between them has a solid foundation. In this type of relationship informed consent can be a negotiated and lengthy process that results in both parties feeling confident about each other's level of understanding.

Partnership in the hospital context

What the 1995 monograph did not attempt to do was describe the relationships that existed between hospital-based midwives and the women they attended. Over a decade later we see these relationships have strengthened and matured but this was a difficult journey for many hospital midwives.

By its very nature midwifery has always been in a privileged position to support women during a life changing event and many midwives and women have experienced beneficial and positive relationships that contain many of the elements of a relationship we later

described as a partnership. Midwives have always been skilled in connecting with women and forming relationships quickly, assisting women to have the most positive experience possible. The essential difference between 'traditional' hospital-based midwifery care and the way we initially described the partnership model was that we located the partnership relationship between the midwife and the woman outside the confines of institutional expectations and protocols. It was our contention that without the roles of 'expert' and 'patient' and the almost insurmountable power dynamics inherent in hospitals, midwives were freed to redefine their midwifery role according to the needs and wishes of women rather than the hospital, and women were freed to determine their own experiences.

This was not a criticism of hospitals or hospital midwifery practice. Every institution struggles with the conflict that exists between the needs of the individual versus the institution's mandate to provide care for the whole community. Maternity services have an added complication in that the vast majority of its clients are not sick and so there is a conflict between the needs of well women and babies and the institutional requirements to also provide acute medical and obstetric services for those that need them. Wherever institutions attempt to provide primary, secondary and tertiary maternity services in the one setting, the needs of the secondary and tertiary services will dominate because their needs are acute and require much more organisation. Midwives working under these conditions are going to experience partnership in quite a different way to midwives out in the community in primary birthing units or at home.

As mentioned earlier, when we wrote the monograph we predicted that moving towards working in partnership as described in the model would be a longer and more difficult process for hospital midwives because of the restrictions placed on autonomous practice by institutional protocols and employment contracts. Professional autonomy struggles to survive within hierarchical institutions that seek to control their workforce through protocols and policies and midwives were no exception to these pressures.

Although the midwifery profession tried to ensure that structures were put in place to develop and sustain autonomy and continuity of midwifery care in all settings, we underestimated the level of resistance from some hospital midwives and their managers, not only to the concept of partnership but also to autonomy. Nor did we anticipate Nursing's continued lack of acceptance for midwifery as a separate profession to nursing, even though by then the legal reality of midwifery autonomy was well established.

Initially the union (New Zealand Nurses Organisation) worked with the College around midwifery team contracts but that was short-lived. Since the union representing the hospital midwives was a nursing one it struggled to have any vision for midwifery that was coherent with the College's view. Rather than work to help employed midwives or hospitals to develop practice autonomy and embrace new models of care the union played on the fears of the midwives and used the tensions inherent in organisations to cement the status quo and resist change .It took hospital midwives some time to develop a sense of identity within this rapidly changing environment and it is only relatively recently that they have claimed partnership as part of this identity.

The impact of this strengthened midwifery identity within maternity facilities can be illustrated in a number of ways. For example hospital-employed midwives have used the midwifery partnership model to argue for changes within the institution that support autonomous midwifery practice. Initiatives taken include the rotation of staff through all areas of the maternity units to update midwives' practice experiences through the childbirth continuum; removing standing orders with the expectation that midwives will use their legal right to prescribe when necessary; and reassessment of staffing levels in acknowledgement of the numbers of caseloading midwives coming into facilities to provide care for their clients.

Discussion is ongoing in relation to the role of the core midwife. A maternity service that utilizes LMC midwives to provide the majority of midwifery care must articulate and negotiate functional roles and relationships between its core midwifery staff and LMC midwives. There are many examples where the interface between core midwives and LMC midwives is integrated and the environment provides support for both. This midwife-to-midwife relationship too is one of partnership. It is based on the same relationship principles as the midwife – woman partnership. Both midwives have a defined role and part to play. Both bring different bodies of knowledge in relation to the woman and the environment. The LMC midwife brings her partnership with the woman and the core midwife supports this through her facilitation of the hospital environment. Both midwives work together to ensure that the woman has the best birth experience she can. The process of drawing on each other's knowledge has an element of reciprocity. Sometimes the LMC midwife will have a wealth of normal birth experience but will rely on the core midwife for advice and support if the woman requires secondary or tertiary intervention. Sometimes it is the core midwife who is less experienced and the LMC can share knowledge with her.

Conclusion

Ten years on we think the principles of the partnership model still hold true. We have watched more and more midwives, both caseloading and core midwives, grow to understand and demonstrate safe, effective and powerful midwifery partnerships with women.

Furthermore over these last ten years there is evidence that the vast majority of women are happy with their relationships with midwives (Ministry of Health, 2003). Emerging trend data also indicates that many outcomes for woman and babies have improved. For example admissions to neonatal units have decreased as have antenatal admissions; perinatal mortality rates continue to decrease; fully and exclusive breastfeeding rates for Maori woman have increased and the first six-week immunization contact continues to be higher than any other point in the child's life (Guilliland, 2004).

However, as in any relationship, a successful partnership relies on the qualities of the partners involved. In articulating midwifery as a relationship it is important midwives do not lose sight of their scope of practice and their competence as a midwife. Whatever the relationship, the midwife must offer the woman her knowledge and skills in a way that contributes to the well being of the woman and her baby. After all that is ultimately the reason why women would want to share their experiences with midwives. Having a positive, reciprocal, and equal relationship is of no use if the midwife abrogates her

professional responsibilities. It is not good enough to be nice and kind without knowledge and the ability to practise with that knowledge. It is not good enough just to offer information and expect a woman to make an informed decision as if she was a midwife. Working in partnership does not exclude active decision-making and direction by the midwife. If normal birth required no action then there would be no point in having a midwife. There is just as much a professional expectation that midwives do take a position from time to time, as there is that women are kept fully informed and involved in their maternity experiences in a way that respects their culture and values.

At every level partnership is about balance. The balance between the midwife's view and the woman's wishes; the balance between research evidence and midwifery intuition; the balance between the culture and beliefs of the midwife and those of the woman; the balance between intervention and non intervention; the balance between a woman's rights and a midwife's rights. Partnership certainly requires more than just the words.

References

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms.* Wellington: Victoria University of Wellington.

Guilliland, K., & Pairman, S. (1995). *The Midwifery Partnership: A Model for Practice.* Monograph Series 95/1, Department of Nursing and Midwifery, Victoria University of Wellington.

Guilliland, K. (2004). A hundred years of midwifery and what have we learnt about ourselves? *Midwifery News,* October, 4-6, 28-29.

Harding, D. (2000). Making choices in childbirth. In L. Page. (Ed). *The New Midwifery: science and sensitivity in practice.* London: Harcourt Publishers, 71 – 85.

Kennedy, H.P. (1995). The essence of nurse-midwifery care: the woman's story. *Journal of Nurse-Midwifery, 40,* (5), September/October, 410 – 417.

Kennedy, H.P. (2002). The midwife as an 'instrument' of care. *American Journal of Public Health, 92,* (11), 1759 – 1760.

.....Kennedy, H. P. (2004). The landscape of caring for women: a narrative study of midwifery practice. *Journal of Midwifery & Women's Health, 49,* (1), 14-23.

Kirkham, M. (Ed). (2000). *The midwife-mother relationship.* London: Macmillan Press.

Ministry of Health. (2002). Section 88 Maternity Advice Notice. Wellington: Author.

Ministry of Health (2003). *Maternity services consumer satisfaction survey.* Wellington: Author.

New Zealand College of Midwives (1989). *Submission on Nurses Act 1977.* Unpublished.

Oxford Dictionary, Fifth Edition, 1963

Page, L. (2003). One-to-one midwifery: restoring the 'with woman' relationship in midwifery. *Journal of Midwifery and Women's Health, 48 (2),* 119-125.

Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery, 15,* 165-176.

Part Three: Midwifery Leadership

Part Three: Midwifery Leadership

Part Three of this thesis explores New Zealand midwifery's second key professionalising strategy, midwifery leadership through the establishment and operation of its professional organisation. I will begin by identifying three main factors for the success of New Zealand midwifery's professional organisation, the New Zealand College of Midwives (NZCOM or College). These expressions of leadership are: the way that partnership is realised through its integration within the structure, processes, policies and activities of the College; the characteristics of midwifery leaders who have led and directed the evolution of the College; and the support and 'ownership' of the College by women and midwives who have embraced opportunities for practising partnership.

In discussing these three reasons for success it is impossible to disentangle the roles played by women and midwives in practising partnership and in supporting the leadership of the College. Without a commitment from midwives and women to the vision and objectives of the College and without their willingness to participate in and to embrace the opportunities for autonomy and partnership, New Zealand midwifery would not have evolved to the strong profession that it is today.

I begin by discussing the expression of partnership within the College and describe how partnership was integrated through the establishment of mechanisms for practising partnership, the articulation of a vision and the establishment of mechanisms for enhancing professionalism. It involves women and midwives in all aspects of its operation.

As with the integrated involvement of midwives and women in the College, leadership is also integral to and integrated in all College activities and is therefore difficult to disentangle. However, I discuss three examples of midwifery leadership in action. These are: funding for autonomy, contesting jurisdiction, and international influences.

In the concluding discussion on leadership I will identify the challenges that I believe face the College as we move on to our next phase of development. As the College becomes

mainstream rather than revolutionary it is essential to strengthen and maintain our key values and ways of working so that as a profession we do not become complacent and inward looking.

Finally I introduce the five portfolio pieces that further explicate and develop the themes discussed in Part Three.

As in Part Two I use the first person rather than the third person when talking about the College. This is not only because I was involved in a leadership role in all of the developments that I discuss, but also because I believe it is important for midwives to claim ownership of the College. It is only through midwives involvement that the College can work because it relies on the participation of members. There is no entity, 'the College' that exists to make decisions about midwifery for midwives. There is no 'them' or 'it' only an 'us'. We are the College.

Leadership through the professional organisation

The New Zealand College of Midwives (the College) is a highly successful professional organisation. From an initial membership of just 50 midwives in 1988 we now represent over 80% of practising midwives and, in line with our partnership model, enjoy membership from a number of maternity consumer organisations and individual women. Whilst some of the remaining 20% of midwives do not belong to the College or a union, some may belong to the New Zealand Nurses Organisation (NZNO) for industrial representation. This organisation does not purport to represent midwifery professionally. The College is the recognised professional voice of midwifery in New Zealand and our vision and leadership have been critical to the consolidation of midwifery as an autonomous profession that is now the main provider of maternity services.

The success of the College can be attributed to three factors. Firstly, the congruence of the College's philosophy of partnership through its articulation in the constitution, structures, processes and policies of the College as an organisation, Secondly, the skills of the

midwives who have led the development and evolution of the College and the midwifery profession, in particular Karen Guilliland, the College's first President and variously, Coordinator, National Director, and now Chief Executive of the College. Third, the support of midwives and women who have embraced the College's vision and run with the opportunities that have been created for them to practise independently and in partnership with each other. I will discuss the first two aspects in turn but recognise that all three factors are intertwined and overlap and that separation is artificial. This is particularly so for the involvement of women and midwives, which is the bedrock upon which all else is predicated.

The College is not a static structure, rather the College is (we are) a living, breathing, moving entity made up of people who are interacting and changing. It is (we are) an evolving entity with a life of its (our) own. Thus any attempt to describe it (us) and analyse it (us) cannot do it (us) justice and at best represents only a moment in time – a snapshot – but even this two-dimensional vision is important and so I will present the College as best I can.

Integrating partnership: congruence of philosophy, structure and process

Practising partnership within the College

Structure

As described in Part Two the constitution of the College establishes rightful consumer (women) membership at every level of the College structure. There are four consumers representing national maternity consumer organisations on the governing body, the National Committee. These four women alongside 10 regional chairpersons (midwives), two Maori midwifery representatives, two student midwife representatives, two Elder midwives or Kuia (one Pakeha and one Maori), the President and the Chief Executive make up the National Committee. This group meets three times a year to fulfil their governance role. The National Committee works in a non-hierarchical and women-centred model that includes extensive consultation processes and consensus decision-making. Each of the 10

College regions has its own regional committee that takes governance responsibility for the region. Consumers can also be members at a regional level. This means that women (consumers) are involved in all of the College processes and partnership is embedded in the fabric of the College.

Each region also has a minimum of two (more in large regions) standing committees, a Midwifery Standards Review Committee (MSR) and a Resolutions Committee. These committees play a vital role in midwifery professionalism, as will be discussed later, and they also provide good examples of the practise of partnership within the College. Midwifery Standards Review Committees are both quality assurance and professional development mechanisms. They are made up of two midwives and two women (consumers) with a mandate from the region to fulfil this review role. Committee members attend national training run by the College to prepare them for their role. The process of Midwifery Standards Review is supportive and educative. Individual midwives present themselves for review each year and present their previous years work for discussion. The MSR committees are provided with the midwife's caseload clinical outcomes, client evaluation forms, the midwife's self assessment against the NZCOM Standards for Midwifery Practice and any other information the midwife wishes to share. The committee and the midwife discuss all this material together in a reflective and supportive process that aims to assist the midwife to identify areas of practice that need further development. The meeting concludes with the joint development of a professional development plan for the midwife, which then becomes the basis for discussion at the next review meeting.

Resolutions Committees are conflict resolutions processes for women and are made up of one midwife and one woman with a mandate from their region. Their role is to provide a resolutions process for women who may be unhappy with the midwifery care they received. The process is voluntary and Resolutions Committees have no statutory authority. However, they can mediate between a woman and a midwife and sometimes that process is enough for the woman to feel that her concerns have been heard and resolved. Thus the resolutions process focuses on women while the MSR process focuses on midwives.

In addition to the College's regional and national structure we have also established three separate but parallel organisations, the Midwifery and Maternity Provider Organisation (MMPO), the Midwifery Employee Representation and Advice Service (MERAS), and the Joan Donley Midwifery Research Collaboration (JDMRC).

The MMPO is a practice management system for caseloading midwives. It has three main activities. First, it provides a conduit between the central primary health funding system of the government and individual midwives by processing claims for service on their behalf. Second it collects maternity outcome data from midwives' claim forms and thus produces a national dataset of midwifery practice outcomes as well as providing individual midwives with their collated annual outcomes and comparative information. Finally it provides a set of Maternity Notes that integrate women's clinical notes with midwifery records, data gathering forms and claim forms. These notes are used extensively by midwives throughout the country and are likely to become the standard form of record keeping within the maternity services.

MERAS is the midwifery union and it negotiates wages and conditions for employed midwives. Established for only two years MERAS is fast attracting membership from the majority of employed midwives.

The JDMRC is a research collaboration named after midwife Joan Donley, the founder of the College and midwife researcher and author. Its purpose is to encourage and facilitate research cooperation between all midwifery education providers and it hosts a forum specifically for new midwifery researchers to present their work in a supportive environment. While the MMPO and MERAS each have their own governance structures, the JDMRC is housed in the College at this stage.

These three organisations were established by the College to meet the specific business, industrial and research needs of midwives that could not be appropriately managed through the professional organisation. Considerable thought went into the establishment of these organisations to ensure that their structure, functions and governance mechanisms did not

become blurred with the College or, in the case of the MMPO and MERAS, did not dissipate the overall strength and unity of the midwifery voice. This was the main risk in establishing these separate organisations. We were worried that once midwives joined the MMPO or MERAS they would find their immediate needs around payment were being met and they would no longer join the College. If midwives could join the MMPO or MERAS separately then there was a risk that midwifery as a profession would become fragmented and lose its united voice. It was recognised that the political influence of a profession is weakened if disparate professional groups no longer speak with one voice (Barnett, Barnett and Kearns, 1998). Therefore action was taken to prevent the dissipation of power.

Thus midwives can only join the MMPO or MERAS if they are first members of the College. The College is also represented on the governance body of each organisation and we provide professional advice to ensure that the practice management or industrial activities of these organisations are congruent with the College's philosophy and professional aims. An example of this cohesion is the recent Collective Agreement achieved by MERAS to cover midwives in all the 21 District Health Boards that employ midwives. It not only improved conditions and pay levels for employed midwives but it framed the industrial document within a professional midwifery model and reflected the need for all midwives to focus on professional codes and practice standards. It paved the way for a new midwifery professional development model for employed midwives that will integrate professional requirements with employer requirements for quality assurance.

Appendix Two provides a diagrammatic representation of the College structure.

Process

Because the College uses a consensus decision-making process, there is a regular flow of information between the regions and the College nationally, and wide consultation on all issues. The regional chair people come to National Committee with a mandate from their regions to make decisions through consensus at a national level. The National Committee employs the Chief Executive, Karen Guilliland, and she in turn employs the staff of the National Office. The National Office staff carry out the day-to-day work of the College. A

large part of this work involves: advice and other services for individual midwife members; dissemination of information; representation of the College's views through submissions; promotion of the College's vision through publicity material, consensus statements and the website; provision of continuing education; and management of MSR and resolutions processes.

The College structure is one of our strengths as it provides the College with mechanisms to maintain communication with our membership and to practise partnership. The National Committee process and the consultation processes ensure that all information is disseminated and discussed at regional level. Thus, when complex decisions have to be made or when midwifery faces attack from another quarter, we have been able to keep all midwives well informed of the issues and the possible actions we think the College needs to take. Therefore individual midwives do not feel they are alone, but can add their voice to the collective voice of midwifery that the College provides.

Collectivism has been important, not only in assisting midwives to take on their professional identity, but also in assisting midwives to take available opportunities for establishing and consolidating their practice. For example, when primary maternity services were being restructured by the government from 1993 to 1996, the College participated in the intense and prolonged negotiations over the structure, service specifications and funding for primary maternity services that provided the current framework for the maternity services. This was known as the Section 51 negotiations and will be discussed as an example of midwifery leadership. During this process we were able to keep members very well informed about the implications for practice as the negotiations were taking place. As a result midwives were well placed to take advantage of the new practice models (Pairman & Guilliland, 2003). By contrast, the New Zealand Medical Association did not appear to have such robust communication or consultation processes and when the final service specifications and funding mechanisms were released many doctors reacted negatively and some withdrew from the provision of maternity services.

Apart from ensuring appropriate mechanisms for partnership, communication and consultation between all midwives and consumer groups in New Zealand, there are two other areas in which the College's work is essential to the development and maintenance of the profession. The first is in articulating a vision for midwifery and working to establish the structures that are required to fulfil this vision. The second is in setting and maintaining standards, professional development and quality assurance mechanisms to ensure that the profession delivers high quality midwifery services. Of course there are other important functions of the College (see Appendix Three for College role and functions), but these two, along with communication, consultation and partnership structures, have been critical to the College's success in establishing midwifery as a profession. I will turn to these now.

Articulating a vision

The College has successfully articulated a vision for midwifery that has not only attracted midwives and women, but over the years has also assisted midwifery to influence other governmental processes that have impacted on midwifery. For example, the College presented a clear vision of what we could offer New Zealand women and the wider health service when we lobbied for the 1990 Nurses Amendment Act. We promoted this vision again through the 1992/3 Maternity Benefits Tribunal when medicine attempted to undermine midwifery's achievement of pay equity for primary maternity services. The College provided a very strong vision, not only for midwifery, but also for the whole maternity service, through the long process of negotiation over the Section 51 Maternity Advice Notice from 1993 to 1996 that established the current structure of the New Zealand maternity services.

In 1998 the College's vision was articulated thus:

> *We want every pregnant woman to think 'midwife' when she discovers she is pregnant. We want every woman to approach childbirth with confidence and joy. We want families to understand that birth is a normal, healthy life event which occurs within the community and over which the woman and her family have control. We want obstetric care to be easily available for those who need it, but not applied to those who don't. We want midwives to understand what it means to be 'with women', for each midwife to have a personal relationship with the woman's ability to give birth and become a mother. We believe that when the majority of midwives in New Zealand practise independently and in partnership with women,*

> *the maternity system will undergo massive change in its power structures, women and their babies will have significantly better experiences and better outcomes, and society as a whole will recognise and uphold childbirth as a normal, healthy life event* (Pairman, 1998b, p.5).

Articulating a vision is not enough on its own. Whilst it helps midwives, women, politicians, civil servants and others to understand the stance midwives are taking collectively and then for midwives and women to embrace and share that vision, it also requires strategic action, often political, to create a context in which the vision can be achieved. Realising this vision also needs commitment from midwives to practise 'with women' in a way that supports women's self-determination.

The vision was always the touchstone for all College activities. College leaders planned and led the strategic action that has enabled this vision to begin to be achieved. Midwives and women embraced this vision and their support and involvement in the activities that gave life to this vision are essential to its achievement.

This vision developed over years of talking between midwives and women and it reflects our understandings of ourselves as a profession that practises in primary health in the community. It reflects our understanding of childbirth as a physiological life event and our role as midwives as 'Kaitiaki' or guardians of this normal process. It reflects our understanding that childbirth is a joyful and transformative process and that women deserve to experience it in this way. While we may agree that we are beginning to achieve some of this vision, in that women are starting to think 'midwife' instead of 'doctor' when they find they are pregnant, and many women enjoy a personal relationship with a midwife throughout the childbirth process, we are only beginning to understand the impact that a women-centred ideology could have on society and we are only now beginning to see evidence that midwifery-led care does indeed improve maternity experiences and outcomes for women and babies (Ministry of Health, 2003; Guilliland, 2004; Guilliland, Tracy & Thorogood, in press).

Midwives may not alter the dominance of medicine in health care but what midwifery as a profession can do is focus on individual midwife-woman partnerships and ensure that each

woman has the best experience of childbirth that she can so that she can begin to challenge some of her own and her family's taken-for-granted assumptions about childbirth. This means ensuring: that midwives practice to appropriate standards; that their education is robust; that they can understand and critique research evidence; that they are reflective and critical practitioners; that they understand their professional midwifery role and responsibilities; that they practise autonomously as midwives; and that they practise in partnership with women. It means expressing a women-centred ideology through the way they practice midwifery (Teijlingen, 2005). In this way midwives can mediate the influence of the medical model ideology and slowly, one woman at a time, can begin to make a difference in how women and their families think about and experience childbirth.

These professionalising activities will be discussed next.

Enhancing professionalism

One of the first activities of the College when we formed was to agree on a philosophy, a code of ethics and set of standards, which would guide our practice as midwives. As was discussed in Part One, forming a professional organisation and setting standards is a common activity of most professions. This is because it is necessary to develop a professional framework into which members of the profession can be socialised. A philosophy and set of standards can help to create a profession's identity because they set out its purpose and its values and assist the professionalism of members. As was discussed in Part One, professionalism involves internalisation of the profession's values and practices by its members. It involves commitment to the profession, dedication to providing 'good' care, and a belief that the work of a profession has value to society. Ultimately professionalism becomes a central life interest through which one defines self.

The first two portfolio pieces in Part Three deal extensively with the formation and evolution of the New Zealand College of Midwives and within these chapters the development of this professional framework is discussed. Therefore I will not discuss this further here except to say that in line with the College's process of consensus decision-making these statements of our professional identity took months to develop and agree. As

mentioned in Part One, partnership with women is articulated as a philosophical stance, an ethical stance and a standard of practice and it is part of the fabric of the College.

As discussed above partnership between midwives and women is also practised through the process of Midwifery Standards Review. Domiciliary midwives first developed this unique professional process in the late 1980s and it was adopted and further developed by the College shortly after we formed. The central defining difference between this and the quality assurance mechanisms of other professions such as medicine and nursing, is that midwives examine and critique their practice 'in partnership' with women. This demonstrates an important shift in power relations. Midwives do not pick which women can review them and the consumer members on the review committees are not merely 'token' appointees. Rather, both the midwife and consumer members are nominated and endorsed from the region and have a mandate for this work. All members of the committee have an equal part to play in the process of review. Midwifery Standards Review is one mechanism the College uses to recognise and action its accountability to women. Discussion of MSR is picked up again in the portfolio for Part Three where Karen and I make the case for MSR as an alternative credentialing strategy. MSR is also discussed in Part Five because it is a central requirement in the Midwifery Council of New Zealand's Recertification Process. MSR provides the link between midwifery's professional and regulatory frameworks in New Zealand.

The College's relationship with midwifery's regulatory authorities has been longstanding. As will be discussed in Part Five the College played an important role in influencing the Nursing Council of New Zealand's regulatory activities for midwives while it still had regulatory responsibility for midwifery. Since the establishment of the Midwifery Council of New Zealand the College has enjoyed a close and cooperative relationship with midwifery's regulatory authority in their shared commitment to ensuring that women and their families have access to high standards of midwifery care.

Similarly to the close relationship of midwifery with the regulatory authority, it has been important for the professionalism of midwifery that the College form relationships with all

providers of midwifery education, both pre-registration and post-registration education. As will be discussed in Part Four, midwifery education is a key professionalising strategy and the profession must be able to set the direction for midwifery education so that it supports midwifery professionalisation and professionalism. Accordingly, the College is represented on the advisory committees for each School of Midwifery, has played an important part in assisting the approval and accreditation processes for each programme, and College representatives and practising midwives are involved in theoretical and clinical teaching of students.

In addition the College facilitates annual meetings of all midwifery educators to assist networking and the sharing of ideas and to ensure that there is congruence between the College's direction and that of the Schools of Midwifery.

These are the ways in which the College works to enhance the professionalism of midwives and create a shared identity as midwives and as a profession. Midwives in the College have led all these activities and I will turn now to look at the leadership role of the College.

College leaders: politicising midwifery

Leadership is an area in which the College has excelled. Leadership occurs in every area of the College because midwives have enormous influence through their roles, not only as midwives, but also in other areas of their lives. Leadership is an inherent part of the midwife's role as we guide and support women through one of life's most extraordinary transitions. Leadership is also practised by midwives who hold formal positions in the regions or on National Committee whereby they help to set the College's direction and translate our message to the wider group and vice versa. However, for the purpose of this discussion I will focus on the more strategic positions of leadership in the College where midwives have led our strategy and necessarily interacted with outside agencies through external processes.

I do not name these midwife leaders individually although many are identified and their contributions discussed in the first two portfolio pieces for Part Three. However, I cannot speak of midwifery leadership in New Zealand without mentioning Karen Guilliland. Her leadership of the College has been pivotal to its success and we have all benefited from her extensive range of skills. Karen's commitment to the vision of the College is unwavering and her ability to see the 'big picture' and devise strategy accordingly is exceptional. However, it is in her people skills that Karen truly excels and she has a wonderful ability to intuitively connect with people. Karen has the ability to bring out the best in those she works with and bring them on board with a sense of passion and excitement. Her contribution to the College and to women in New Zealand cannot be underestimated.

From the start College leaders devised a strategy for managing our political activity. There are a number of elements to this strategy as follows: the College is always represented by two or more midwives and we never attend meetings alone; presentation material is of a high standard as we learnt early that presentation is important in establishing credibility; arguments are evidence-based where possible and passion and 'real life' practice stories are equally important in articulating our vision; networking is used to gain support from maternity consumer groups and resources are shared to ensure everyone is taking a similar approach; networking with women is reciprocal and the College adds its support to the issues of women's groups as well; College representatives remain united in their approach and focused on the main objective, and they adopt a conscious strategy to remain calm, even in situations of extreme hostility.

I will turn now to three examples of College leadership in action. All involve political activity. The first concerns the strategic importance of funding for midwifery; the second concerns the importance of claiming jurisdiction over our work; and the third involves the College's influence on international midwifery.

Funding for autonomy

When midwifery autonomy was reinstated in 1990 midwives who offered primary maternity care in the community were entitled to claim a fee-for-service from New

Zealand's state-funded Maternity Benefit Schedule. The schedule comprised a set of payments that reflected the kind of maternity care given by general practitioners. Midwives entered the schedule at the same rates of pay as doctors because importantly the 1990 Nurses Amendment Act also provided pay equity of midwives with doctors in the provision of primary maternity care.

Only two years later medicine challenged midwifery's achievement of pay equity through a Maternity Benefit Tribunal hearing. This was our first serious challenge and we had no funding and no established infrastructure of staff and resources to help us. I was appointed as the College representative on the Tribunal, along with a medical representative, two public representatives and a Queen's Counsel (as chair). While the Medical Association hired a Queen's Counsel to take their case and lawyers from the Crown Law Office represented the Health Department, the College relied on the skills of Karen Guilliland and Steph Breen, a midwife and Director of the Nurses Organisation at that time. These two presented a conclusive case and pay equity was upheld. It was the quality of the presentation and the evidence-base, the passion and the real-life practice inherent in the arguments that led to this success. Karen and Steph called a series of impressive midwife witnesses whose sound understanding of the issues could not be undermined by questioning from the opposing parties.

By contrast the questioning of medical witnesses revealed their different understandings of childbirth as a medical event as opposed to midwifery's understandings of it as a life event. This was demonstrated by the priority medical witnesses gave to certain clinical assessment skills such as vaginal examination over continuous support for women and the more subtle signs of progress in labour; the priority they gave to their role over women's self care or strength in labour; and the invisibility to medicine of midwifery practice which they perceived as an adjunct to their more important role. It was sobering for those of us present to see how little medicine understood or valued what midwifery had to contribute to women in childbirth, or even to medicine. This was all the more disturbing because doctors had worked closely with midwives over so many decades and yet many did not even recognise how midwives practised.

Midwifery's understanding of the arguments and our knowledge of the wider maternity service and roles of doctors and midwives, demonstrated conclusively that general practitioners and midwives both provided primary maternity services. Even though the two professions provided this care differently, there should be equal pay for equal work. This was a landmark victory for midwifery because it upheld midwives' equal place with medicine in the provision of primary maternity services. From this position midwives have been able to successfully compete with doctors to become the main providers of primary maternity services. That midwives and doctors were paid the same meant that midwives received payment for services that were greater than would have been the case without the bargaining power of medicine. The principle that midwives and general practitioners provide the same maternity service now underpins New Zealand's maternity service and is another critical factor in midwifery's success in becoming the main provider of maternity services.

This principle of equal pay for equal work held unshaken during the protracted negotiations over the Section 51 Maternity Advice Notice that replaced the Maternity Benefit Schedule. These negotiations began in 1993 and the first round lasted three years. They were part of a wider government strategy, driven by New Right philosophy, to scrutinise the social services of the welfare state (Barnett, Barnett & Kearns, 1998). The health system was restructured to separate funding from the provision of service and to create markets for health, in the belief that this would widen choice, increase efficiencies and ensure greater accountability for use of public funds. The funding agency carried out a nationwide consultation about a new modular framework for maternity services that would replace the open ended, practitioner directed, fee-for-service model that had been in place since 1938 (Coopers & Lybrand, 1993). Negotiations commenced between the New Zealand Medical Association, the New Zealand College of Midwives and the funding agency, to decide the minimum service specifications for the structure and the level of funding attached to each module. This was the first time there had been any attempt to set a minimum standard for maternity care or to define what care each woman was entitled to receive.

Medicine used this process to try and relitigate the Tribunal findings, but it was unsuccessful. The lack of success of the doctors in undermining midwifery's position was mainly due to the small but consistent team of College representatives who attended every meeting over that three-year period. Karen and I were part of this team and we worked hard to counter the doctor's arguments and also convince the Health Authority officials who were managing the process. That these officials were mainly women probably helped midwifery's case, because they had an analysis of childbirth as a woman's issue. Despite this understanding maternity consumer groups were not represented at these negotiations. If it had not been for the College's commitment to partnership and our insistence that a consumer was part of the College's negotiating team, there would have been no direct consumer voice to the process.

The process of negotiation was lengthy, difficult and at times hostile, when for example, the Medical Association refused to meet in the same room as the College or when doctors presented anecdotal evidence to demonstrate that midwifery care was unsafe. On reflection, some doctors were out of step with the socio-political climate of that time. The 1989 Cartwright Report had led to significant public distrust of doctors and called for more accountability and transparency from all health professionals. The woman's health movement of the 80s had led to expectations of 'choice' and 'informed decision-making' in health care. Medicine's resistance to change on the basis of their professional authority and power was not a strategy that worked in this changed context.

Interestingly obstetricians appeared to understand the changed reality of the socio-political climate, where general practitioners did not. There were many times during these negotiations when obstetrics supported midwifery. Of course obstetrics was not threatened by midwifery as these negotiations were about the primary maternity service and whilst they provided primary services their uncontested area of expertise was in secondary and tertiary care. It suited obstetrics to support midwifery and define general practitioner expertise in maternity as primary care. By doing so obstetrics could ward off any challenge from general practice to its control of the tasks around complicated childbirth.

Another dynamic at play in the Section 51 negotiations was the New Right market and management driven ideology that characterised government policy in the first half of the 1990s. These policies promoted competition and contracting; separated policy from provision and funding from service delivery (Gauld, 2001). It suited the government to set midwifery and medicine in competition with each other, and indeed it became obvious to us that one government agenda was to eventually remove the single centralized payment system for maternity services altogether and devolve the funding through processes of contracting and competition.

Therefore, while working to retain a centralised funding model for primary maternity services (on the basis of equity, access, and consistency) the College was forced to establish its own Midwifery and Maternity Provider Organisation (MMPO) as a separate organisation, which could act as a national contracting agency for midwifery services if the central maternity funding mechanism was removed. If all midwives joined the MMPO instead of attempting to win contracts for small group practices of two or three midwives, they would continue to have a united voice and be able to negotiate collectively from a position of strength. Through this mechanism midwifery would have a better chance of maintaining its pay equity achievement. Initially the formation of the MMPO was a 'just in case' strategy but as discussed earlier it has come into its own in later years as providers of a midwifery practice management system for midwives claiming from Section 51 (now Section 88). The MMPO remains ready to be a national contracting agency for midwives if this should be required in the future.

As events evolved Section 51 was not devolved but the threat remains, as current government priority is to organise providers of primary health services into multi-disciplinary Primary Health Organisations (PHOs). I will not discuss PHOs in this thesis except to say that midwifery is aware of the potential threat of joining an organisation such as this that is likely to be dominated by medicine. The strategies of midwifery leaders have been to persuade government to delay further devolution of primary maternity services while the rest of the health system is still in the throes of major restructuring. The current maternity system works well and there is no advantage in destabilising it at this time.

However, the government policy direction is clear and these delaying tactics may only stall the inevitable change. In the meantime midwifery is working to strengthen and consolidate midwifery practice so that any future negotiations can take place from a position of strength as the main provider of primary maternity services.

The Section 51 Maternity Advice Notice provides the government's policy direction for the primary maternity services. Following the negotiations described above it was released in 1996, and revised in 1998. It presents an innovative structure for New Zealand's maternity service. The fee-for-service model has been replaced with a modular system for antenatal, labour and birth and postnatal care. Each module has associated service specifications that set out the minimum expected level of care that must be available for every woman and the fee payable for that module. It requires a pregnant woman to choose a Lead Maternity Carer (LMC), a midwife or a general practitioner or an obstetrician, who has responsibility for coordinating all care and providing most of it. The document begins with a vision statement:

> *Each woman and her whanau and family, will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice. Pregnancy and childbirth are normal life-stages for most women, with appropriate additional care available to those women who require it. A Lead Maternity Carer chosen by the woman with responsibility for assessment of her needs, planning her care with her and the care of her baby, and being responsible for ensuring provision of Maternity Services, is the cornerstone of midwifery care in New Zealand* (Ministry of Health, 2002, p.11).

The consistency with midwifery's vision is clear and the influence of midwifery through this document is undeniable. The Section 51 (now called Section 88) negotiations were in effect a dispute over jurisdiction. The area in dispute was normal childbirth. Midwifery constructed this as a normal life event and continuous episode that required woman-centred support and observation and that could just as easily take place at home as in a hospital. General practice, on the other hand, constructed it to fit with its model of practice. That is, a potentially dangerous, episodic event requiring technological assessment and intervention, and a team of health professionals to provide labour and birth care in hospital.

Midwifery's construction of childbirth fitted with the socio-political context of that time where 'choice' and 'accountability' were part of the public's priorities for health care (Coopers & Lybrand, 1993). Midwifery's construction also suited obstetrics because midwifery clearly claimed a scope of practice that interfaced with obstetrics rather than competing with it. It was also a model that suited the Ministry of Health and Treasury. This was firstly because it removed the profession-directed fee-for-service model and replaced it with capped fee modules that also, for the first time, set out professional and contractual accountabilities for service provision. Secondly, by requiring women to choose a midwife or a general practitioner or an obstetrician the model set up an element of competition that operated even though each professional group was paid the same for each module of care that they delivered. This market driven model presented both opportunities and threats to midwifery and this is discussed further in the following portfolio for Part Three.

The maternity service framework achieved as a result of the Section 51 negotiations provides a women-centred continuity service that recognises homebirth as a valid choice and gives women the right to choose the LMC. It enables smooth integration of primary, secondary and tertiary maternity care in a continuous process and according to women's individual needs. It is a model that suits midwifery perfectly, reflecting as it does the midwifery scope of practice. It is a world first and it has provided a framework that has enabled midwifery to become the main provider of primary maternity services.

Karen Guilliland, in particular, understood the importance of midwifery retaining equality with medicine in the provision of maternity care. Even though the modular payment system with its 'swings and roundabout' approach does not always fully reward midwives for their time, it has ensured that the centralised funding mechanism remains in the meantime and that the principle of pay equity with medicine is upheld. The ability of midwives to claim payment from this centralised fund has been the single most important factor in midwives' abilities to build their independent practices. Midwives in New Zealand do not have to be employed unless they choose to be. As self-employed practitioners they are answerable to their clients and to the profession but they are not restricted by employment obligations or

hospital institutional controls. This gives midwives considerable freedom to develop their own models of practice and to create a profession that is unique.

By contrast, the newly recognised profession of midwifery in Alberta, Canada, has not been able to consolidate its professional status largely because, unlike midwifery in Ontario and British Columbia, midwifery services were not included in the public health care system of funding. This has meant that midwives have had to charge women a fee for their services (McKendry & Langford, 2001). Despite having formed a professional organisation in 1995, and achieving legislated professional status through Alberta's Health Professions Act in 1999, the lack of public health funding has meant that more than half of Alberta's midwives have ceased practising and midwifery's professionalisation process has been impeded (ibid). Aspects of midwifery professionalisation remain in limbo in Alberta. Midwifery education programmes have not been established and amendments to legislation enabling midwives to practise autonomously, such as hospital admission and discharge privileges, have not been made.

McKendry and Langford (2001) contend that midwifery in Alberta was a victim of the post-1993 New Right government ideology that set aside bureaucratic initiatives in health care and focused instead on major cuts in government spending. While midwifery achieved professional status through legislative changes that purported to establish new professions as alternatives to the exclusive scope of practice privilege of medicine, there was no government support for its integration into the public health care system. McKendry and Langford (2001) make the point that state support for midwifery in Ontario and British Columbia was introduced with significant support from women electors and feminist presence in the legislature. In contrast, Alberta's bureaucratically led initiative lacked the political support it needed to drive the changes through in the face of a different government agenda.

This comparison between New Zealand and Alberta highlights the significance of the socio-political context to the success of the professional projects of midwifery in both countries. In Alberta midwifery was promoted to professional status through state

bureaucratic initiatives that sought to license and regulate health care occupations in order to provide challenges to medical dominance. This agenda was supported by the Centre-Right government of the day but without strong public support it could not survive the different agenda of the New-Right government that took power soon after midwifery autonomy was achieved (McKendry and Langford, 2001). In New Zealand public demand for midwifery autonomy in order to provide 'choice' for women drove the legislative changes and was supported by all political parties as a result of extensive lobbying carried out by midwives and women. As a result midwifery's professional status is embedded in the public health system enabling it to operate as a fully functioning profession. While New Zealand also experienced a change of government immediately after the legislative changes were made, its New-Right government recognised the potential of another provider to compete with medicine and thereby create efficiencies, increase consumer choices and provide greater accountability for public expenditure (Barnett, Barnett and Kearns, 1998).

Contesting jurisdiction

By claiming jurisdiction over normal childbirth midwifery gained the power to determine what 'normal' is. This has always been a point of tension between midwifery and obstetrics. Indeed it was one of the reasons why doctors fought so hard against midwifery legislation in Britain in 1902 (Witz, 1992). The 1904 Midwives Act in New Zealand did restrict some tasks but doctors were still reliant on midwifery diagnosis of abnormality in order to provide medical interventions as required. By the time the 1925 Nurses and Midwives Registration Act was passed in New Zealand there were no restrictions legislated and midwives were entitled to *"attend a woman in childbirth in any case where a registered medical practitioner has not undertaken responsibility for the care of the patient"* (Nurses and Midwives Registration Act, 1925, p.21). As we have seen the 1971 Nurses Act removed midwifery autonomy by giving doctors responsibility for the care of all pregnant women.

Because childbirth is a normal life event and it is socially and culturally constructed it has never been possible to consistently define when it is 'abnormal'. Professor Bonham attempted this in New Zealand in the early 80s by providing an all-encompassing list of 55

potential 'risk' factors that required a woman's care to be transferred to an obstetrician (Bonham, 1983). But this was unworkable and met significant resistance from women as well as general practitioners who rightly suspected that this was a strategy to shift childbirth from their control to obstetrics. When the Nurses Act was amended in 1990 there was no legislative restriction over what midwives could do. However, in the lead up to the legislation the College had argued that midwifery's scope of practice was 'normal childbirth' and it was only through professional standards and guidelines that the line between 'normal' and 'abnormal' could be determined, and then only individually.

After the Section 51 Maternity Advice Notice was completed government agencies made an attempt to gain agreement between midwives, general practitioners and obstetricians as to when pregnancy and childbirth was 'complicated' and required specialist care. A set of Referral Guidelines was developed through a long process of consultation and negotiation. The resulting document highlights the difficulty with making 'rules' as these do not take account of individual variation or necessarily, women's choices (Ministry of Health, 2002). The Referral Guidelines are introduced with a statement about decision-making:

> *The guidelines recognise that General Practitioners, General Practitioner Obstetricians and Midwives have a different range of skills. The guidelines are not intended to restrict good clinical practice. There may be some flexibility in the use of these guidelines.*
>
> *The practitioner needs to make a clinical judgement depending on each situation and in some situations may require a course of action that differs from these guidelines. The practitioner will need to justify her/his actions should s/he be required to do so by their professional body.*
>
> *It is expected that the principles of informed consent will be followed with regard to these guidelines. If a woman elects not to follow the recommended course of action it is expected that the practitioner will take appropriate actions such as seeking advice, documenting discussions and exercising wise judgement as to the ongoing provision of care.* (Ministry of Health, 2002, p. 31).

Three levels of referral were identified. Those where the LMC may recommend to the woman that a consultation with a specialist is warranted (level 1) given that her pregnancy, labour, birth or puerperium (or her baby) is or may be affected by the condition; those where the LMC must recommend to the woman that a consultation with a specialist is

warranted (level 2); and those where the LMC must recommend to the woman that the responsibility for her care (or her baby's) be transferred to a specialist (level 3). In each case the following words are added:

> *Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three-way discussion between the specialist, the LMC and the woman concerned* (ibid, p.31).

These Referral Guidelines place professional judgement alongside women's choice with the expectation that professionals provide appropriate information in order for each woman to choose the course of action that best meets her needs. They recognise that women may not always choose the same course of action as the practitioner. They also attempt to guide professional behaviour by requiring a three-way discussion that includes the woman in order to agree how professional roles will be shared. These guidelines reflect a social and legal context in which consumers have 'choices' and 'rights' that all professionals must uphold (Health and Disability Commissioner Act 1994).

The Referral Guidelines remain as guidelines and are not policies. While providing guidance they still rely on primary practitioners (now mostly midwives) to make the assessments from which all decisions will flow. As has always been the case medicine continues to rely on midwifery to make the diagnosis that something is wrong or going wrong and to refer appropriately.

In this sense midwifery enjoys wide jurisdiction in childbirth services and the interface between midwifery and obstetrics is negotiated through midwifery judgement. Nevertheless midwifery has chosen to restrict our scope of practice to *"pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn"* (Midwifery Council of New Zealand, 2005). New Zealand midwifery has always been cognisant of the risk in extending our scope beyond six weeks postpartum. From time to time government agents have suggested that midwifery could care for babies up to one year of age but midwifery has resisted these suggestions and they have not been followed through.

Internationally, the American College of Nurse Midwives has tried to convince the International Confederation of Midwives to change its definition of a midwife to extend the scope into well women care (see footnote i). Interestingly these calls have come from countries where midwives do not have jurisdiction over the midwifery scope of practice as defined by the international midwifery community. In seeking to extend the scope the American College of Nurse Midwives and others may be seeking international support for their own jurisdictional claims over another area of practice, such as well women care, where they believe they have a greater chance of success.

New Zealand midwifery has been amongst those countries that have resisted this move and the outcome of this debate is expected to be determined at the forthcoming Congress of the International Confederation of Midwives in Brisbane in July 2005 (Guilliland, 1999). Opposition to the extension of the midwifery scope of practice into areas of women's health and child care beyond six weeks has been led by countries like New Zealand, the Netherlands and the United Kingdom that have an autonomous model of midwifery practice. In these countries midwives understand the complexity that is already involved in providing care for the short time span of pregnancy, labour, birth and the postnatal period to six weeks without increasing the expectations on midwives to provide care beyond this time.

New Zealand midwives have watched with concern the 'burn out' of Maori midwives whose iwi (tribe) have expected them, as trained professionals, to care for women and families well beyond six weeks after birth. These expectations can be difficult for Maori midwives to resist from a cultural perspective and the College is advocating on their behalf with iwi groups to establish more realistic expectations of what midwives, alone, can do to address health issues amongst Maori that result from inequitable access to resources. Jane Sandall's (1997) study on the impact of continuity of care on midwives' work and personal lives identified three important factors in avoiding burn out, sustaining practice and providing flexible women-centred care as occupational autonomy, social support and the development of meaningful relationships with women. For New Zealand midwifery maintaining professional autonomy is essential to attaining the other two factors and

therefore midwifery needs to be constantly vigilant to potential internal or external threats to midwifery autonomy.

As Abbot (1988) suggests, jurisdictional settlements are not permanent and are subject to continuous interprofessional competition. Midwifery in New Zealand is certainly aware of the potential instability of its jurisdiction over normal childbirth. This can be challenged, not only by another profession such as medicine, but also as a result of external factors such as the rise of technology in childbirth. External factors such as this have the potential to increase public demand for certain interventions such as epidural pain relief. This in turn impacts on midwifery care as it changes the midwife's role from facilitator to technician. If midwifery's role is no longer valued by women then it becomes more vulnerable to challenges from other professional groups who seek to claim jurisdiction over normal birth through use of exclusionary or demarcationary strategies.

International influence

As my final example of midwifery leadership provided by the New Zealand College of Midwives I will briefly discuss our influence on midwifery internationally. There are two ways in which this influence has been expressed. The first is the College's activity within the International Confederation of Midwives (ICM). The second is through College leaders and others attending international midwifery forums to speak about New Zealand midwifery and through publications that explain New Zealand midwifery's unique model of practice to midwives and others with an interest in midwifery.

In the early 1990s New Zealand's notion of midwifery as a partnership with women and our inclusion of women (consumers) in our professional organisation met with some resistance from the international midwifery community. In 1993 New Zealand attempted to influence policy of the International Confederation of Midwives by putting forward two remits. The first, a position statement on midwifery partnership, was accepted but the second, a proposed constitutional change to recognise consumer membership in professional midwifery associations, was defeated (Guilliland and Pairman, 1993). While the international midwifery community was willing to take on the philosophy of

partnership it was not willing to sanction the enactment of this philosophy within midwifery associations. A similar remit was again defeated in 1996 (Guilliland and Pairman, 1996).

The complexities of an organisation such as ICM, that attempts to represent the united voice of over 79 midwifery organisations from countries with vastly different socio-political, economic and cultural structures and vastly different systems of midwifery practice, make it difficult to bring about radical change. However, New Zealand's model of partnership has been articulated to some degree through the processes of ICM and thereby has influenced midwifery practice in many parts of the world. For example, midwives who attended the ICM Asia-Pacific regional conference in Bali in 2000 gave New Zealand a standing ovation for our presentation on midwifery partnership (see Pairman, 2001 in Part Four Portfolio). It was the translation of partnership as a 'ground up' movement that drew this response from midwives. This notion of women and midwives together making change goes to the heart of midwifery practice and is recognised as a practical change that is within each midwife's control no matter what her practice context.

Formal presentation and publication of New Zealand midwifery's model of partnership is one way of articulating New Zealand's unique contribution to midwifery's knowledge base. As perhaps the only country in the world with a fully integrated midwife-led and women-centred maternity system, New Zealand midwives are also in unique position to research and write about midwifery practice issues; outcomes of midwifery-led care; the partnership between case-loading midwives and core midwives; relationships between women and midwives and midwives and midwives; and concepts such as 'independence', autonomy', 'power sharing' and 'partnership'. As discussed above, the College can facilitate this research and share New Zealand midwifery's understandings with the international midwifery community through the Joan Donley Midwifery Research Collaboration, through our Journal and newsletter and through continuing to encourage midwives to publish and present in other international forums.

Discussion

The main purpose of the New Zealand College of Midwives is to create an identity for midwifery, lead its professionalisation process and promote professionalism as the expression of midwifery's social contract with women. The way that the College fulfils these roles is through its (our) leadership of the profession.

Midwifery's central philosophy of partnership is given expression through the constitution, structures, processes and policies of the organisation. Through a participatory and consensual process the College developed a vision that midwives and women could embrace and that politicians and bureaucrats could understand. Supporting this vision is the College's professional framework. Through articulation of philosophy, ethical standards, and standards of practice this framework identifies what midwives offer to women, how they work with women and how they conduct themselves in relation to women, colleagues and wider society. This professional framework expresses midwifery's core values of commitment to women's self-determination and midwifery partnership. Membership of the College and participation in its (our) processes assists midwives to identify with the profession and deepen their commitment to the profession and to their work as midwives.

Strategically, College leadership has ensured that external structures and processes, such as funding mechanisms, provide a platform from which midwifery has been able to successfully develop its women-centred and midwife-led model of practice. In claiming normal childbirth as our scope of practice midwifery has wide discretion over the interface with obstetrics as, whilst there are guidelines for referral, these acknowledge individual differences and women's choices as inherent in decision-making processes.

As a profession then, midwifery has autonomy to practise according to its professional standards and these standards emphasis partnership, responsibility and accountability. For individual midwives the learning about autonomous practice, partnership practice, and concepts such as responsibility and accountability begins in midwifery education programmes and develops through midwifery practice and through involvement in the College's quality assurance process of Midwifery Standards Review.

Through all these processes the New Zealand College of Midwives has developed a professional identity and practice that rejects certain notions of profession such as 'self-interest', 'client dominance' and 'exclusion', but claims instead a 'new' professionalism, which is women-centred, egalitarian and inclusive. Central to this identity is midwifery's definition of itself 'in partnership' with women.

Tully (1999) contends that in constructing midwifery as a partnership between midwives and women the College is promoting a feminist form of practice in which women are in control of their birthing experiences and midwives work to improve childbirth services for women. By emphasising the women-centred nature of our professional identity midwifery has used gender as a resource in our claim of jurisdiction over normal childbirth (Davies, 1996; Witz, 1999). It was through emphasising our 'with women' partnership model of practice that midwifery gained support from women and a social mandate for midwifery autonomy 'in partnership with women' over normal childbirth. Midwifery's professional framework is how midwifery upholds this social contract with women.

The key elements of this framework are midwifery partnership and normal childbirth. Midwifery partnership is what distinguishes us from medicine in the provision of maternity care and these partnerships and support from women will strengthen midwifery against attempts by medicine to encroach on our jurisdiction. These jurisdictional disputes occur in the margins between professional scopes and are constantly shifting from a variety of internal and external pressures (Abbott, 1988).

There is the potential for midwifery to be destabilised from inside the profession too. As midwifery consolidates as the main provider of maternity services there is a danger that it will become institutionalised and complacent. There is a potential to become 'inward looking' and 'self-interested' and to take on some of the characteristics of profession that were so roundly rejected when the College was first established. To guard against this the College needs to ensure that we have strong partnership processes in place and that midwifery is always listening to what women are saying about the kind of care they are

receiving from midwives. Midwifery's dominant position in the delivery of primary maternity services does not mean that we should stop questioning our practice, challenging ourselves to improve the outcomes of our care for women and babies and working to expand our knowledge base and improve standards of care. Midwifery also needs leaders and there is a risk that if we cannot grow the leaders of the future that midwifery will not be equipped to recognise or act on potential threats to our jurisdiction. The College needs to be aware of these possible challenges and to work on ways to prevent these problems developing.

When midwifery regained professional autonomy in 1990 it already had a legislated title, 'midwife' and a system of controlling entry to the profession. However, nursing not midwifery controlled these heteronomous means of closure and it was imperative for midwifery to establish autonomous means of professionalisation through the College in order to take control of how midwifery evolved its new professional status. As has been discussed the leadership activities of the College have been directed to: consolidating a 'new' professional identity founded on partnership; articulating a professional framework to support this philosophy and identity; finding ways to use external structures and processes to midwifery's advantage so that the profession has a supportive funding framework within which to practice; and sharing midwifery's unique model of practice with the international midwifery community. Part Four of this thesis will explore midwifery education in relation to midwifery professionalisation and Part Five focuses on midwifery's heteronomous means of closure through mechanism of self-regulation.

As has already been stated in this thesis, it is the congruent expression of midwifery partnership in practice, policy, politics, education and regulation that characterises New Zealand midwifery. I explored midwifery partnership in Part Two and have now examined policy and politics in Part Three. Education and regulation remain. But before I turn to them I will discuss the portfolio associated with Part Three.

Linking the portfolio

The next section of Part Three of this thesis provides five pieces of work that more fully explicate the leadership activities of the New Zealand College of Midwives. The first two pieces are chapters for a book on the development of the New Zealand College of Midwives that I am co-writing and editing with Karen Guilliland and which is due for publication in 2006. The third piece is a chapter I wrote for a book published in 2002 on critical issues in nursing in New Zealand. This chapter provides an overview of midwifery's separation from nursing and the establishment of a midwifery identity through the New Zealand College of Midwives. The fourth piece is an article jointly written with Karen Guilliland and published in the NZCOM Journal in 2001. This article discusses Midwifery Standards Review as a credentialing strategy. The final work is another chapter jointly written with Karen Guilliland that was published in Mavis Kirkham's book on birth centres in 2003. That chapter discusses the establishment of a women-centred and midwife-led maternity service in New Zealand.

Each of these five pieces provides a different focus on midwifery leadership through the New Zealand College of Midwives. What will become apparent through these pieces is the diversity of activity that the College has undertaken and the complexity that is involved in providing the structures and framework necessary for autonomous midwifery practice in partnership with women. When we began we had no idea of the amount of work that would be involved. However, as will become evident through these pieces, the strength of vision and commitment of midwives and women to the philosophy and practice of partnership were the driving force that kept the profession going.

Part Three: Midwifery Leadership Portfolio

List of portfolio pieces

Pairman. S. & Guilliland, K. (forthcoming). The resurgence of midwifery. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

Pairman. S. & Guilliland, K. (forthcoming). The evolution of a professional organisation. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

Pairman, S (2002). Towards self-determination: the separation of the midwifery and nursing professions in New Zealand In E Papps (Ed) *Nursing in New Zealand. Critical issues. Different perspectives*. Auckland: Pearson Education.

Pairman, S & Guilliland K. (2001). Midwifery Standards Review: a strategy for credentialing. *New Zealand College of Midwives Journal, 25*, October, 23-28.

Pairman, S & Guilliland K (2003). Developing a midwife-led maternity service: the New Zealand Experience. In M. Kirkham (Ed)_*Birth Centres. A social model for maternity care.* Books for Midwives Press, London.

Locating the work

These five pieces provide a sample of work I have undertaken to explore the role of midwifery leadership through the New Zealand College of Midwives during the period of study for this Professional Doctorate. Congruent with a 'professional doctorate' these works are a result of my professional practice as a midwifery leader and midwifery educator during 1999 to 2005.

As discussed above the leadership of the New Zealand College of Midwives is the recognised voice for midwifery in New Zealand and has been instrumental in establishing a strong, autonomous midwifery profession that is now the main provider of maternity services in New Zealand. It has achieved this through strong vision, strong leadership and strong support from midwives and women.

The College has established a professional framework for practice that reflects the key philosophy of midwifery partnership and it has established a professional organisation that supports this framework though its structure, policy and processes. College leaders have worked strategically to ensure that the external structures of the maternity services in New Zealand work to provide a platform for autonomous midwifery practice in partnership with women. In so doing the College has successfully developed a women-centred and midwife-led maternity service through which midwives can honour their social contract with women.

I have been involved in this work since I joined the Midwives Section of the Nurses Association in 1984. My political career as a midwife began in 1986 when Karen and I represented the Midwives Section at the Nurses Association conference and this political involvement continues to this day. I was the chairperson of the Otago Midwives Section when we formed the College and disbanded the Midwives Sections. I followed Karen as the second President of the College for a five-year term from 1992 to 1997 and I was made an honorary member of the College at the end of my term as President. The Minster of Health then appointed me to the Nursing Council of New Zealand where I was one of two midwives on the regulatory authority for nurses and midwives for the next three years. In 2003 the Minister of Health appointed me to the newly established Midwifery Council of New Zealand where I was voted the inaugural chair. Therefore my political career in midwifery spans almost twenty years and I have influenced many of the professional activities discussed in this thesis.

For all of that time I have worked closely with my friend and fellow midwifery-politician, Karen Guilliland. Therefore it is fitting that a number of pieces in this portfolio were written in partnership with Karen.

The first two pieces are chapters from the book that Karen and I are writing together about the New Zealand College of Midwives. As I explained in the introduction to the portfolio for Part Two, this book brings together our recollections and experiences with as much documentary evidence as we could find to provide an historical record of the New Zealand College of Midwives from our perspective. The focus of these chapters is on the formation of the College in our transition form Midwives Section to College. The second chapter details the beginning professional activity of the College and the evolution of our professional framework.

The chapters are very detailed, first, because we wanted midwives to understand our thinking and our strategies, and second because we wanted to try and record the involvement of so many of the midwives and women whose participation and leadership will otherwise be lost to history. As I said above, the life of the College is our membership and it is this most of all that we want to explain. There is no College; there is no profession, without a shared commitment to the work of making it happen.

The third piece was written for a book about nursing issues in New Zealand. I was asked to write about how midwifery reclaimed its professional identity. For several years after the 1990 Nurses Amendment Act there seemed to be many nurses who felt somehow rejected by midwifery's actions in leaving the Nurses Association and forming our own organisation. Perhaps too there was an element of jealously about midwifery's autonomy and professional status. Many nurses were unaware of how this had come about and I wanted to explain the history to them. I tried to explain why midwifery saw itself as separate to nursing even though many of us at that time were also nurses. I wanted to show why midwifery believed that the nursing professional organisation could not represent midwifery and that our views were divergent on some key issues. I finish the chapter by

suggesting that there is potential for collegiality between the two professions that can strengthen both.

The fourth piece is an article jointly written with Karen that was published in the College Journal in 2001. This article was first written in 2000 but not published. We updated it and published it in 2001 because of our growing concern that the credentialing processes of medicine could be inappropriately applied to other health professional groups including midwifery. Karen and I had represented the College at several meetings called by the Ministry of Health to discuss credentialing. The Ministry expressed strong support for credentialing and we were concerned at the potential for midwifery's scope of practice to be fragmented or limited by employer priorities. This paper makes the case that midwifery already has a credentialing process called Midwifery Standards Review and that this is the mechanism that should be used to ensure midwifery competence. We used the Ministry's credentialing framework to show how this could work. Some four years later midwifery is still not part of the Ministry's credentialing process and Midwifery Standards Review is the central component of the Midwifery Council's Recertification Programme to ensure midwifery competence. This will be discussed in Section Five.

Finally, the fifth piece in the portfolio is another chapter jointly written with Karen and published in the United Kingdom in 2003. This chapter was also invited and our brief was to write about birth centres in New Zealand as an environment for autonomous midwifery practice. As New Zealand has very few of these we wanted to show how home birth and primary maternity units fulfil the role of birth centres and how the structure of the maternity service can support midwifery autonomy and midwifery partnership with women.

Writing for an international audience we have provided contextual information about New Zealand and about the history of midwifery in this country. We explained how New Zealand midwifery achieved a women-centred and midwife-led maternity service that integrated primary, secondary and tertiary maternity services in a seamless framework. We explored the economic and political influences on health and maternity services and explained how vigilant midwifery has to be to hold its position within this shifting context.

This chapter also discusses the relationships between caseloading and core midwives and explains how the role of core midwives has evolved as a result of midwifery autonomy.

These five pieces each takes a different approach to the discussion of midwifery leadership and need to be read together with the overall discussion provided earlier. Each piece has a different style by this is appropriate to the intended audience.

Pairman. S. & Guilliland, K. (forthcoming). The resurgence in midwifery. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

[Note this is an unedited version prior to publication and changes may be made as part of the editing process]

Chapter Four: The resurgence of midwifery

This chapter traces the development, role and function of the New Zealand College of Midwives as the professional organisation for midwives, which led the development of midwifery as a profession in New Zealand. It begins with an account of the Midwives Section of the New Zealand Nurses Association and examines the reasons why New Zealand midwives needed to set up their own professional organisation, separate to nursing. This chapter describes the formation of the New Zealand College of Midwives and the transition from the Midwives Section, including the early professional activities of the College and their importance in establishing a strong foundation for the ongoing development of the College as discussed in chapter five.

The Midwives Section of the New Zealand Nurses Association

The New Zealand Nurses Association (now the New Zealand Nurses Organisation) was the only professional and industrial organisation available for nurses and midwives until the late 1980s. It developed from the New Zealand Trained Nurses Association (NZTNA) that was established in 1909, as a network and professional voice for nurses. Midwives joined the NZTNA and the NZNA because their numbers were so few that a separate organisation was considered unnecessary. However, the different interests of midwives were recognised to some extent when the Midwives Section of the New Zealand Nurses Association (NZNA) was formed in 1969 to enable midwives to join the International Confederation of Midwives (ICM). The initial focus of the Midwives Section was therefore on international midwifery activity.

When we first joined the Midwives Section strong midwives, mainly from Auckland, such as Ann McQueen, Anne Nightingale, Penelope Dunkley and Glenda Stimpson were key figures. There was a loose organisation of regional committees and a National Midwives Section, which was based initially in the Auckland Region.

Carol Hosken, Ruth Moore and Rhondda Davies from the Otago Region took on the National Chairperson, National Secretary and National Treasurer roles respectively in 1986. One of their major achievements was improving communication and unity amongst the regional sections to develop a stronger national voice for midwives. The National Committee, comprised of the chairs of each of the regional midwives sections, met regularly to develop national strategies. Carol and Ruth also strengthened midwifery's ties with the International Confederation of Midwives, an action that was to stand midwives in

good stead in future years as it was the international community that provided New Zealand midwives with the evidence to support their arguments for autonomous practice.

Under Carol and Ruth's leadership the Midwives Section took a more proactive role in strengthening the midwifery profession. An early strategy was the 1985 'What is a Midwife? Campaign' that was undertaken to raise awareness of the role and professional identity of midwives amongst both midwives and the general public. This campaign originated from the Otago Midwives Section. It involved the dissemination of posters with photographs of midwives in practice (all in uniform in hospitals as this was the norm of the day), and pamphlets describing the role of the midwife and citing the World Health Organisation definition of a midwife. The campaign also actively persuaded midwives to change their name badges from 'Staff Nurse' to 'Staff Midwife' and encouraged women and their families to mention the word 'midwife' in their birth notices in newspapers. This campaign was as much about getting midwives to reclaim their midwifery identity as it was about educating the public about the role of the midwife and its possibilities for women and their families. It was also the first time that we really understood the importance of presenting our arguments in a way that was visually attractive and professionally credible.

The posters and pamphlets were professionally produced, albeit through making use of personal contacts, primarily midwives' partners and friends. Like many other women's groups trying to make change with limited resources, we used all our personal relationships and contacts to make things happen. The Section received sponsorship of $600 from the Ministry of Women's Affairs to help towards the printing of the 'what is a midwife?' pamphlets (National Midwives Section, 1986). During these years midwives received considerable support in the form of political and strategic advice from the Ministry of Women's Affairs, as its advisors understood midwifery to be a women's health issue.

Another strategy to raise awareness of midwifery was the implementation of an annual National Midwives Day to promote and market the midwife and her role. The International Confederation of Midwives later took up this idea and an International Midwives Day is now celebrated every year on 5 May.

Differences with nursing

From its inception the Midwives Section recognised that its perspective on midwifery differed significantly from that expressed in New Zealand Nurses Association (NZNA) policy. The Midwives Section struggled to have its voice heard and because the number of midwife-members within the larger nursing organisation was so small, midwives found that Nursing's views took precedence. For example, a major and long lasting disagreement between NZNA and the Midwives Section was over midwifery education. Another was over the definition of a midwife.

Midwifery education

NZNA policy reflected Nursing's view that midwifery was a post-basic nursing specialty. Consequently they promoted midwifery education from 1979 as an option within the Advanced Diploma of Nursing (ADN), a new post-registration nursing programme based in the polytechnic educational institutions rather than the hospitals. The Midwives Section disagreed and successfully used the democratic process of NZNA to have remits passed at

NZNA conferences in 1980, 1982 and 1985 for support of a one-year separate midwifery education programme. While these remits should have meant a change in NZNA policy, NZNA chose only to action the remits by writing to the Minister of Education. In July 1985 the Minister replied that midwifery education would be dealt with as part of the "thorough" overall evaluation of the Advanced Diploma of Nursing that was being undertaken at the time. This response continued to be passively accepted by NZNA seven years after the midwives initial request for action (NZNA, 1987).

Definition of a midwife

Another area of disagreement between NZNA and the Midwives Section was around the definition of a midwife. NZNA policy since 1981 was that a midwife was a "nurse," whereas the Midwives Section wanted NZNA to adopt the World Health Organisation (WHO) definition of a midwife as a *'person'* (NZNA, 1981). In 1985 the Midwives Section succeeded in persuading NZNA to adopt the WHO definition, although the 1981 policy statement itself was not amended until 1989 (NZNA, 1989).

The disagreements over midwifery education and the definition of a midwife were instances where the predominately nursing membership supported midwifery but the organisation and its leadership failed to act on this support and the changes that were democratically agreed.

Role confusion

Role confusion between nurses and midwives was another point of conflict that created a barrier to midwifery's progress towards autonomy on a number of occasions. The 1981 Policy Statement on Maternal and Infant Nursing (NZNA, 1981) is an example of the division that existed between midwives as much as the division between nurses and midwives. The working group who developed this policy included Margaret McGowan, National President of the Midwives Section at the time. The policy not only defined midwifery as nursing, it also sought to restrict the practice of domiciliary midwives by recommending their employment by hospitals and their regular review by professionals in the Department of Health. It was not seen as necessary to recommend similar reviews and practice restrictions for hospital midwives. The policy statement appended a Statement on Home Confinement submitted by the Midwives Section that reflected the confusion of hospital midwives about women's rights and expressed the midwives' maternalistic value system. The statement portrayed women choosing home birth as 'vociferous' and 'fanatical' (NZNA, 1981). It identified domiciliary midwives as the only group of midwives that required additional education, monitoring and surveillance (ibid).

Not surprisingly this policy statement provided the impetus for domiciliary midwives to separate from the NZNA and the Midwives Section and form their own organisation, the Domiciliary Midwives Society of New Zealand (Donley, 1986). This separation of hospital and homebirth midwives continued for some years until legislative changes in 1983 and 1986 highlighted the need for unity. The Domiciliary Midwives Society continued to advocate for home birth and for homebirth midwives through the 1990s, although by then it worked in collaboration with the New Zealand College of Midwives providing another supportive voice for midwifery's professional directions.

Separating from Nursing

Despite the successful changes to NZNA policy on midwifery, NZNA continued to block midwifery's aims by refusing to enact the policy in any meaningful way. We remember how incensed midwives were in 1985 when at a meeting in Christchurch on midwifery education, Patricia Carroll, Director of NZNA, told Midwives Section representatives that with 22,000 nurses and only 600 midwife members, such a small group could not expect to sway the opinions of the nursing profession. Karen remembers this as the first time that the Midwives Section publicly declared that it would be better off outside of NZNA since it could never compete on numbers.

Once midwife leaders within the Midwives Section understood their essential powerlessness within the NZNA, discussions about separation into a specific midwifery organisation began. Fortuitously Massey University Nursing Department and Social Science Extension jointly ran a five-day residential workshop on midwifery in August 1986. Many of the 100 midwife participants had been sponsored to attend by their employers. This was the first time that midwives were able to access the resources to gather together in such large numbers.

The vision of those midwives and nurses who organised the Massey Workshop, Norma Chick, Marion Pybus, Irene Madjor and Judy Hedwig, should not be underestimated. The Massey Workshop was a turning point for midwifery as it brought so many midwives together nationally to talk about what midwifery meant to them and to reclaim their midwifery identity. The organisers invited the participating midwives to think about their role, their purpose, their theoretical base and philosophical beliefs and succeeded in developing a sense of unity amongst all those present. The process of the workshop enabled midwives to develop a collective vision for midwifery professionalism. The Workshop also gave midwives a national forum to discuss the implications of separation from NZNA as one of the strategies for strengthening midwifery's professional identity.

NZNA was worried about the threat of midwifery separation and sent several representatives to the first National Midwives Section conference in Christchurch in September 1986. Midwives did discuss separation and the conversations concentrated on resources, indemnity insurance and how midwifery would represent itself. There was a range of views for and against separation. It was agreed that there needed to be wide consultation and investigation of all the options. NZNA itself was restructuring and many midwives considered that if midwifery were actively involved in those discussions it might be able to secure a stronger voice in the future structure. It was decided to explore all avenues and not to rush to a decision. This decision appeared to have reassured NZNA. Lorraine Sivyer, NZNA President, reported back to the NZNA Executive after the conference

> *"...our anticipation of a breakaway did not occur in reality. They will look at the feasibility of setting themselves up as an organisation. They had the information as to the cost and the implications of this. I sensed the climate was timid at the moment and certainly the political awareness was not as astute as we might have believed"* (Sivyer cited in Donley 1986, p7).

Indeed the decision to separate and establish a midwifery professional organisation involved two more years of consultation and investigation. In those two years there were several more events that reinforced the inability of NZNA to effectively represent midwifery's needs.

In 1986 and 1987 there was some activity in relation to midwifery by NZNA, mostly instituted as a response to the increasingly frustrated Midwives Section. The NZNA Annual Report 1986-87 records the following resolution:

> *"that the NZNA treat as urgent the need to change Section 54(2)(a) of the Nurses Act 1977, as amended by the Nurses Amendment Act, 1983, Section 17, so that nurses who direct and supervise obstetric care are also registered midwives"* (NZNA, 1987, p. 33).

NZNA's response to this direction from its membership was to report that a letter written in July of 1986 to the Minister of Education had received a reply in September the same year. The Minister, Michael Bassett, said:

> *"The Department agrees that midwives working in hospital should be registered as nurses also. However, it is not practicable to legislate for this at the present time. I am satisfied section 54(2) of the Nurses Act 1977 does not detract from the high standard of qualification and experience of nurses providing obstetric nursing care in hospital settings. Consequently I see no need for a further amendment to the provision to provide a dual qualification"* (Bassett cited in NZNA, 1987, p.33).

This response is interesting on several levels. Firstly, NZNA had done nothing until 1986 about the remit passed in 1985. NZNA then accepted the Minister's response with no further action in spite of the fact that the Minister's response indicated a misinterpretation of the original request. That is, that all midwives should be nurses rather than the intention that all nurses providing and supervising obstetric care should be midwives. Secondly, the Minister would have received this advice from the nurses within the Department of Health. At that time those nurses relied on the advice and policy direction of NZNA. Again midwifery's voice was being blocked by nursing.

In 1987 the Wellington region of the NZNA, at the request of the Wellington Midwives Section, proposed the remit:

> *"That the NZNA request the Minister of Health to amend section 54 (1) of the Nurses Act 1977 (amended by the Nurses Amendment Act 1983 S17 (1)) to enable midwives to be autonomous practitioners in normal birth"*
> (NZNA, 1988a, p. 44).

Because the Sections of NZNA were unable to be delegates to the annual conference in their own right they were required to take their remits through the branch structure of NZNA. As one way of promoting midwifery's views some Midwives Section Chairpersons participated at committee level of NZNA Branches and were able to attend the NZNA conference as part of the regional delegate groups. However, in 1987 the National Midwives Section was given leave to speak to the remit. The remit was passed with no dissension from the floor.

That same 1987 conference was a watershed for us personally. We attended the conference as observers on behalf of Carol Hosken and Ruth Moore (National Section Chair and Secretary at that time) who were away at the ICM Conference in The Hague. During the report back on actions in relation to remits passed in previous years, we heard that NZNA would be attending a meeting the following week with the Department of Health and the Department of Education where decisions would be made about the future of midwifery education and a working party set up to implement them. This came as a shock as the Midwives Section had not been invited to the meeting and indeed knew nothing of the background conversations that led to the meeting. Previously intimidated by the formal and highly bureaucratic nature of the conference itself, our indignation fired us with the courage to march up to the front of the hall to challenge their decision not to involve midwifery. Pat Carroll, retiring Executive Director, refused to talk to us. However, Gay Williams, incoming Executive Director, nervously conceded that the process was flawed and grudgingly allowed us to attend the planned meeting the following week.

Talk about lambs being led to the slaughter! Little did we know that this was the beginning of months of the most horizontally violent, disgracefully vindictive processes we would ever experience. It was nursing at its worst and it strengthened our resolve that if midwives were ever to improve childbirth services midwifery had to remove itself from the control of nursing.

Separate Midwifery education

That first meeting to discuss midwifery education set the tone as we were quickly marginalised into midwife radicals set against the reasonable and benign nursing establishment. Present at the meeting were Sally Shaw, Chief Nursing Officer, Workforce Development, Di Reed Principle Nursing Officer Department of Health, Gay Williams, Executive Director NZNA, Merion Litchfield, NZNA, Bev Robb, Head of Department of Nursing Christchurch Polytechnic, Wendy Ohlssen, Head of Department of Nursing Waikato Technical Institute, David Moira, Executive Officer Department of Health and ourselves.

Sally Shaw outlined the context for proposals she had put to the Minister of Health for the future funding of midwifery education. For several years courses had been available to enable psychiatric and psychopaedic nurses to 'bridge' to Comprehensive Nursing registration. The bridging courses had been reassessed and it was clear that their end was in sight. There was a possibility for this funding to be reallocated to separate midwifery programmes. Since there was no new funding for health education this was the only way new initiatives such as separate midwifery courses could be funded. However, it did mean that any midwifery programmes would be confined to those tertiary institutions that had previously run bridging programmes. The options presented by Sally Shaw for midwifery education were

- Direct entry
- Status Quo, ie. remain with A.D.N. programmes
- Separate midwifery programmes
- Dual option of some separate course and some remaining in the A.D.N.

Lastly the discussion also indicated an option was to deregulate nursing and midwifery in favour of certification rather than registration.

We were completely unprepared for both the dual option and the deregulation suggestions. The Midwives Section had never considered either in any serious way and here we were charged with an instant decision. Fortunately deregistration was received by all with nervous anxiety and it was agreed that more time was needed to consider it.

Not surprisingly there was adamant and unequivocal opposition to the direct entry option and we felt there was no point in alienating the group further if we were going to make any progress towards the next best option of separate courses. In one of the many notes on the side we were to make to each other during the meeting, Sally wrote "*Can't flog a dead horse*!" In a later telephone conversation between Sally Shaw and Karen when Karen was trying to explain the reasons and passion behind the direct entry lobby Sally Shaw said it would be '*over her dead body*' that direct entry would ever eventuate! The conversation was held in the community antenatal clinics in South Auckland where Karen was working at the time. When she put the receiver down the five pregnant women waiting in the room all started clapping. It seems Karen had convinced them on the value of direct entry and they were delighted to hear someone take on the establishment. This conversation however illustrated for us the duplicity of the process since direct entry had been put forward as if it was an actual option when clearly the Minister would be left in no doubt by his advisors that it was not.

The dual option of keeping the A.D.N. and having "pilot" separate courses was seen by all the others as the compromise they could take. Clearly they believed if the evaluation was difficult and intensive enough the separate courses would fade away and the A.D.N. would once again predominate. When the conversation became seriously heated we decided reluctantly to concede to the dual option in case we lost the separate course option altogether. This made us extremely nervous since we didn't really know what the consequences would be and how the Midwives Section would feel about the option. We stated that we could not give a final decision until we had consulted with the wider Midwives Section membership.

It was also made clear to us that the substance of the discussion would be reported to the Minister of Health by Sally Shaw and that any decision would be the Minister's. We were further instructed that the substance of the discussion including the four options was to remain confidential. This further increased our anxiety as the culture of the Midwives Section (and now the New Zealand College of Midwives), has always been to share all information and to arrive at decisions through a process of consensus. We were so distressed by this directive that we phoned Sally Shaw two days later and eventually got her agreement that we could discuss the issues with the Midwives Section membership.

This meeting was our first foray into serious politics and we were nervous wrecks at the end of it. We were distressed at a number of levels. Firstly we had virtually been forced to agree to a decision about the preferred option on behalf of all Midwives Section members when we had no idea what they would think. Secondly we had to agree to keep the discussion confidential and therefore would have no way of checking out our decision.

Thirdly, we were shocked to find that Gay Williams did not support her own organisation's policy to support separate courses when she spoke against the separate option on behalf of NZNA. After the meeting we found ourselves in an underground shopping centre in the centre of Wellington shaking and feeling sick about what had happened. We remember phoning Steph Breen, an NZNA Organiser and midwifery leader in her own right, as she was the only person we knew who would understand the politics of both the Health Department and NZNA and the implications of the meeting for midwifery. We were reassured by Steph's analysis that we had little choice but to agree with the majority at that point. However, we decided that we did need to challenge some of what had happened and this led to the phone call to Sally Shaw described above. We also went to see Gay Williams and had a heated discussion with her about her responsibility to present NZNA policy rather than her individual views. Gay apologised and agreed to prior meetings with us so that we could present a united stand in the future.

Unfortunately we were to come into conflict with her again when she took exception to the information we distributed to the Midwives Section members as part of our consultation over the options. Gay objected to us identifying direct entry as a discussed option and reporting some of the background to the discussion, specifically the discussion around deregulation of midwifery and nursing which she felt to be *"a misrepresentation of what took place"* (Letter to selected NZNA members from Gay Williams 19/10/87). In our response we argued *"that government policy shows a trend toward deregulation...it is not unreasonable that nurses and midwives will be affected by this. It is important therefore that we are prepared to be proactive on this issue"* (NZNA National Midwives Section letter to members 19/10/87).

We have reported this first meeting on midwifery education in detail because it illustrates the significant differences in culture between midwifery and nursing and our growing understanding that the professional development and maintenance of midwifery would always have less priority than nursing within the NZNA, even when there was policy supporting the midwifery view.

Following the meeting the Department of Health set up a working party on Midwifery Education, Bridging and related Short Courses to implement the Minister's decision to provide midwives with a dual training option. From 1989 *"midwifery education would be available separately from the Advanced Diploma of Nursing* (Press Statement from combined ministers of Health, Education and Women's Affairs, 7/12/87). Interestingly Helen Clark, soon to be architect of the Nurses Amendment Act, was Minister of Women's Affairs at that time. The purpose of the working party was to plan the implementation of the separate programmes.

Too little too late

Despite the low priority of midwifery within the organisation, the NZNA did make some attempts to address the needs of midwives, particularly once midwives began to seriously talk about separating from NZNA. In March 1986 they set up an Ad Hoc Committee on Maternal and Infant Health. This was in response to the Midwives Section concern that the existing policy statement on maternity was out of date. The Midwives Section had been

requesting since 1984 that the 1981 Policy Statement on Maternal and Infant Nursing be updated (NZNA, 1981).

This time the Midwives Section was able to nominate the majority of the committee members. They were Steph Breen, then National Secretary of the New Zealand Nurses Union; Jenny Johnson, domiciliary midwife and tutor, and Carol Hosken, hospital midwife and President, National Midwives Section. NZNA appointed Eve Brister from their Professional Services Committee and Glenda Foster, Principal Nurse Kenepuru Hospital and member of the NZNA National Executive. The committee's secretary was Joy Bickley, NZNA Professional Advisor and also a midwife. As part of the committee's work a consumer survey was carried out to canvas the views of women about midwifery services. 140 responses were received from 38 consumer organisations (NZNA, 1989).

This was the first time that NZNA involved consumers in its policy making process and it did so because of the influence of midwives and the midwifery profession wanting to move towards a more women-centred service. Joy Bickley, in particular, was very supportive of this approach and it was she who conducted the survey and published its results. Midwifery wanted the involvement of women to characterise future childbirth services and the survey marked the profession's emerging commitment to this goal. The committee was highly consultative and midwives throughout New Zealand had several opportunities to comment through their regional Midwives Section. The resulting policy statement was an innovative, exciting, women-centred document that midwives felt truly expressed their vision for midwifery.

On reporting to the NZNA Annual General Meeting in September 1988, Steph Breen said of the policy, *"the culture of midwifery is acknowledged. To know our future we must know our past. It is also a welcome in from the cold for our domiciliary midwife colleagues"* (NZNA, 1988a, p.30). The Midwifery Policy Statement declared its support for direct entry midwifery education, separate midwifery education programmes, home birth and midwifery autonomy. Included in the appendix were the New Zealand College of Midwives Standards of Practice, because by the time the policy statement was published one year after it was tabled, the Midwives Section had been disbanded and the New Zealand College of Midwives had been established as the professional organisation for midwives. Although officially an NZNA document, the Midwifery Policy Statement was midwifery driven and therefore duly recognised by the New Zealand College of Midwives as a founding policy document.

Forming the College

By the time the NZNA Midwifery Policy Statement was released midwife members of the Midwives Section of NZNA had already separated from the NZNA and formed a professional organisation for midwives, the New Zealand College of Midwives.

In December 1987 the Canterbury/West Coast Midwives Section had taken over from Otago as the National Section[1]. The priorities for the Midwives Section at this time were

[1] Karen Guilliland, National Chairperson; Norma Campbell, National Secretary; Kathy Anderson, National Treasurer.

the ongoing development of the Standards for Practice, Service and Education (to be discussed later) and the continuing discussions about separation from NZNA. This discussion came to a head in 1988. By 1988 NZNA itself had recognised the conflict between its industrial and professional roles. It identified weaknesses in the organisation and consulted with members about restructuring (NZNA, 1988b).

The submission on restructuring from the National Midwives Section identified its concern that the proposals would not address the inherent weakness in one organisation attempting to amalgamate both professional and industrial representation. The Midwives Section proposed that the new structure *"must recognise the separate and specialist roles of professional and industrial matters"* (Midwives Section, 1988a, p.2.). It was the Section's view that the N.Z.N.A. structure currently struggled to fulfil either role adequately. The Section further proposed,

> *"That sections are responsible and recognised as dealing with professional matters and that A&R (Advisory and representation) committees be utilised for industrial matters. Regional meetings are ways of bringing all nurses/midwives and professional/industrial matters together* (Midwives Section, 1988a, p.2).

The Section outlined the heavy professional workload it had carried in the previous year and concluded, *"We believe this is directly related to the structure of NZNA. Either NZNA does not fully meet our needs or our perception of what we need is different"* (Midwives Section, 1988a, p.2). When the NZNA restructuring discussion document was released it appeared that the new structure would not meet the needs of midwives any better than the previous one (Midwives Section, 1988b). While NZNA restructuring did respond to some issues midwives had raised such as representation at national level, the principles of separate mechanisms for professional and industrial representation and regional autonomy were not accepted. Midwives did not believe that the new structure would strengthen their professional voice or the autonomy of the Midwives Section to develop and maintain midwifery professionalism. At the same time midwives were not clear about what structures would meet their needs.

For many years midwives had been hindered by the belief that if they left NZNA and formed a separate midwifery organisation, this would need to be both a union and professional organisation. It is important to recognise that at the time this belief was almost ideological within nursing and midwifery circles throughout the world. It was inconceivable that a professional organisation could survive without the industrial activities or that professional and industrial issues could be separated in any way. As a consequence most midwives struggled to understand how separation could work.

It was not until they understood the significance of the new Labour Relations Act coming into effect in April 1989 that alternatives to NZNA representation were suddenly seen as possible. Until then NZNA had unchangeable and exclusive coverage of midwives under the State Sector Act. From April 1989 the Labour Relations Act enabled coverage of midwives to become contestable. For midwives such as Karen Guilliland and Steph Breen, the possibilities of this new legislation were revolutionary. It was now understood that it was possible for midwives to separate professionally but negotiate industrial representation with other unions or continue to be represented industrially by NZNA.

At the request of the National Midwives Section Karen wrote a paper outlining the midwifery representation choices now possible (Midwives Section 1988c). Midwives could form a separate professional organisation and register this under the Incorporated Society Rules. For industrial representation there were three options:

1. Midwives could join their professional organisation and forgo industrial representation. It was noted that hospital employed midwives were actually represented by default as they came under the NZNA nurses award.
2. Midwives could join the professional body and continue to belong individually to NZNA for industrial representation.
3. All midwives could remain within the Midwives Section of the NZNA. This option was contingent upon the NZNA restructuring process renaming the organisation as the 'Nurses and Midwives Association', and section representation on regional and national councils with voting rights on professional matters. It was noted that this option would mean an improved but still diluted midwifery voice within the organisation (Midwives Section, 1988c).

The process of consultation with midwives about these choices included dissemination of the options paper to section members through the regional chairpersons, special meetings in each region to discuss and indicate preferred choices, discussion at the Midwives Section AGM following reports from regional chairpersons and a postal ballot to every section member unless regions chose to meet locally and decide in block.

These discussions about separation from NZNA were held in the wider context of industrial change for nurses. A precedent had been set by the recent formation of the New Zealand Nurses Union. This union, led by Steph Breen, was established to represent nurses working in the private sector. The impetus for separation from NZNA was similar to those facing midwives, ie. small numbers, lack of autonomy and lack of voice within the larger organisation. The Nurses Union also became important for the development of the new midwifery organisation. Karen, with the blessing and understanding of the Midwives Section, went to work for the union in order to gain experience with contracts, negotiation and employment law. Working for the union gave Karen, as Chair of the National Midwives Section, access to knowledge and information that would be crucial to the development of the new midwifery organisation. As a strong feminist organisation the union provided a positive role model to the fledgling New Zealand College of Midwives. Its clearly articulated principles around women's work and pay equity were invaluable to the College when negotiating the Maternity Benefit Schedule in later years.

Midwives or Moas?

The National Midwives Section conference in 1988 was the culmination of years of discussion and indecision about separation from the nursing profession. It proved to be a watershed in that Joan Donley with her paper, Midwives or Moas, challenged midwives to take a stand and reclaim their profession by forming an organisation that would enable this to happen (Donley, 1988a). Joan was a homebirth midwife from Auckland who had been a visionary leader for midwives and her women clients for many years. She urged midwives to support the establishment of a College of Midwives. The timing for this was right as the National Midwives Section had by now consulted widely on the options for representation

and the National Committee meeting immediately prior to the conference had endorsed its support for a separate professional organisation. The conference AGM also endorsed this decision when it voted to *"accept the principle of, and set up the College of Midwives"* (Midwives Section, 1988a).

A further amendment called for the establishment of a working party to progress this decision. While some regions still expressed hope that the NZNA would restructure in a way that would be midwife friendly, the motion to establish a College of Midwives was carried unanimously. In the excitement of the moment 52 midwives and women stepped forward and pledged a dollar a day towards the establishment of the College of Midwives. Following the AGM nominations were called for the working party. This working party had both consumer and midwife members.[2] It was accepted from day one that this new professional organisation would only be successful if it continues to have the support of women and the maternity consumer movement.

At its first meeting on September 3 1988, 16 members of the working party spent 6 hours working on the structure, administration and constitution of the College (Donley, 1988b). Prior to the meeting the working party had been given a summary of all the recommendations and comments that resulted from the wide-ranging consultation through the Midwives Sections in relation to the name of the College and its structure and functions. They had a draft constitution based on the existing constitutions of the National Midwives Section and NZNA, collated by Auckland midwife, Barry Twydle. The working party changed these constitutions significantly to incorporate the philosophy of the National Midwives Section, membership categories and consumer rights. The constitutional objectives were further developed and enhanced by the interim Board of Management to reflect the midwifery philosophy.

The working party recommended a structure for the College based on that of the current midwives sections. There were to be 11 autonomous regions (changed at the inaugural AGM in 1989 to 10 regions), each able to choose their own structure and each with a regional representative. These regional representatives were to make up the National Committee along with the Board of Management and three consumer representatives. The National Committee made policy decisions and was to meet at least four times per year. At this stage it was envisaged that the Board of Management would rotate as various regions would be elected to take on this role. The members of the Board of Management were then to be elected from this region. The Board of Management was to meet fortnightly and to employ a part-time secretary. It was envisaged that each region would send representatives to the NZNA workplace meetings and to meetings of other community groups such as the National Council of Women, Parent Centres and Home Birth Associations (Donley, 1988c).

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[2] Midwives: Joan Donley, Anne Nightingale, Sarah Hodgetts, Aileen Coppock, Helen Walker, Joan Skinner, Karen Guilliland, Viv Gordon, Betty Jenkins
Consumers: Judi Strid, Lynda Williams, Robyn Bryant
Midwifery students: Dawn Holland, Heather Jackson (Maori)
Maori Representatives: Ellen Tito (Council of Maori Nurses)
Midwives Section representatives: Sally Pairman (Dunedin), Jenny Johnson (Wellington), Glenda Stimpson (Auckland), Lynley McFarland (Northland).

The main area of contention was the name of the College. The suggested 'Aotearoa College of Midwives' favoured by the working party met strong resistance from almost half the membership who felt that 'Aotearoa' would be unknown internationally and that 'New Zealand' College of Midwives' was a more appropriate name at this time. The working party, while disappointed, was not prepared to hold up the process of establishing the College because of the name. The working party recommended the establishment of an interim Board of Management to be made up of the three current office bearers of the National Midwives Section (based in Christchurch) and the three office bearers of the Canterbury/West Coast Midwives Section[3] (Donley, 1988c). The Board of Management was to finalise the constitution, manage the finances and get the College fully functional at all regional levels by March 31st 1989. Essentially it was to undertake a caretaker role until the College's first AGM when nominations would be called for a new board[4]. The working party also recommended that sections should hold workshops to educate and inform members about issues in relation to the Treaty of Waitangi and biculturalism (Donley, 1988c). At its second meeting on 9 October 1988 the working party handed over to the interim Board of Management based in Christchurch (Donley, 1988c).

On 31 October the Board of Management sent out information packages to all Midwives Section Chairpersons and consumer groups that included the proposed structure of the College. The package also included the final draft of the constitution, the Canterbury/West Coast Regional rules as an example for other regions to help formulate their own, guidelines about how to wind up the sections and open the college regions and membership forms. A postal ballot of members was held to ratify the constitution so that the College could function until the inaugural AGM. Each region worked hard to ensure that consumers were able to be represented or to participate in the establishment of the regional committees.

A competition was held to find a design for the logo of the College. Ten entries were received and two were short-listed. Jane Stojanovic from Eastern/Central Region designed the chosen logo, which reflects the midwife/woman partnership. The process of transition from Midwives Section to College of Midwives meant that in the end the birth of the College was straightforward. The Midwives Sections were already functioning well due to the commitment of individual midwives to strengthening the profession. The establishment of the College finally gave these midwives the autonomous midwifery organisation they had been seeking.

The Midwives Section rules required each section to make its own decision on the distribution of its assets or surplus funds on dissolution of the section. Therefore each section was able to transfer its finances to the new College region as the sections were dissolved. The National Section funds, capitated from the 11 sections, amounted to

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[3] Karen Guilliland, National Chairperson; Jacqui Anderson, National Secretary; Kathy Anderson, National Treasurer; Anthea Franks, Canterbury/West Coast Chairperson; Julie Hasson, Canterbury/West Coast Secretary; Del Lewis, Canterbury/West Coast Treasurer.

[4] In the event the Canterbury group was rolled over for another year until 1990 when the National Committee voted to move the Board to Wellington.

approximately $29,000 and these were transferred to the New Zealand College of Midwives (Board of Management, 1989a).

At the National Section Committee meeting on the first of April 1989 Karen Guilliland declared the National Midwives Section of NZNA closed and formally opened the first meeting of the National Committee of the New Zealand College of Midwives. The retiring National Committee of the National Midwives Section and the incoming National Committee of the New Zealand College of Midwives were mostly the same people[5]. In a written report to this meeting, the Board of Management said of its first eight months,

> *"We have spent hours of discussion amongst ourselves and with anyone else who would listen. We have written and received many letters from individuals, section chair people, consumer groups, politicians and international midwifery bodies. We believe the constitution and objectives of the college reflect the thoughts, ideas and demands of this wide cross section of our community. We are excited and pleased with our future prospects and we hope the last four newsletters have helped generate the same excitement for college members"* (Board of Management, 1989b, p.1).

The inaugural AGM held on April 2nd endorsed the Board of Management activities and the decision of the National Committee to appoint Karen Guilliland as the first President of the New Zealand College of Midwives (NZCOM) and recognise Joan Donley as a Founder and first honorary member. It formally accepted the constitution of the New Zealand College of Midwives and further supported the consumer focus of the College when the two remits calling for restrictions to consumer membership were lost. These two remits proposed that membership of the Board of Management and the National Committee be restricted to midwives (NZCOM, 1989a).

The New Zealand College of Midwives constitution was unique in that it enabled consumer membership and participation at regional and national levels as well as providing for consensus decision making in line with its underpinning feminist principles. Following the AGM the NZCOM celebrated its inauguration with a cocktail party at a Canterbury stately house. Midwives, politicians, consumers, obstetricians and general practitioners, maternity managers, NZNA, Council of Maori Nurses, polytechnics and the Canterbury Area Health Board attended this party. The Home Birth Association, Maternity Action Alliance, Parents Centre, La Leche League and Save the Midwives were the consumer groups who came to give their support. This celebration was the first time we had done anything as social. It was a concerted effort to raise awareness of midwifery and NZCOM as part of the health service. Such was our political correctness at the time that we had extensive discussions about the appropriateness or otherwise of having a cocktail party and celebrating with alcohol.

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[5] Northland: Lynley McFarland; Auckland: Glenda Stimpson; Waikato/Bay of Plenty: Maureen Leong & Colleen Yarworth; Taranaki/Wanganui: Kathy Glass; Eastern/Central: Beth Strong (outgoing) & Julie Kinloch; Wellington: Carey Virtue & Helen Cussins (outgoing); Nelson: Marjory Toker; Canterbury/West Coast: Anthea Franks; Otago: Sally Pairman (outgoing) & Suzanne Johnson; Southland: Jemma McArthur. The Board of Management (based in Christchurch) were also members of the National Committee of NZCOM.

By the second NZCOM National Committee meeting in July 1989 the membership had expanded to include the three consumer representatives.[6] While consumer membership was always a priority the College needed time to organise a process for the consumer groups to nominate and elect their own representation. We undertook a wide consultation process with every women's health group we could identify as having an interest in maternity issues. We received several nominations from a wide variety of groups. We organised a postal ballet of all these groups and of consumers already members of the College and the three consumers were elected from this ballot. We have continued to use this process for subsequent consumer representatives.

The second National Committee also included two representatives from Nelson as this was the only region to have continued on with its Midwives Section whilst also establishing a College region. The Waikato region also demonstrated some initial confusion about the College when it established a midwives section solely to seek funding from NZNA for a midwifery workshop. Neither Nelson nor Waikato Regions had any intention to undermine the College and their initial confusion was eventually resolved. At this meeting the National Committee resolved to give formal notice of the dissolution of the Midwives Sections to NZNA. In the October 1989 meeting the National Committee decided to invite Joan Donley to attend all future National Committee meetings as a resource person with full speaking and voting rights. In later years this position evolved to one of 'Elder' and 'Mentor'.

Maori representation

It wasn't until November 1990 that the National Committee began to seriously consider its Maori representation. This lack of action was primarily due to a hesitation around the appropriate way to proceed in the absence of a collective Maori midwife group to give advice. The committee applied to the Ministry of Health's workforce development fund for a grant to begin development of Maori midwifery and its voice within the College. In 1991 the National Committee sought advice from Irihapeti Ramsden about how to establish a consultative process with Maori. Irihapeti was a Nurse Consultant and Maori activist. She was to later become an honorary member of the College for her work on cultural safety and her input into midwifery's understandings of partnership with Maori. Her advice was to contact the National Council of Maori Nurses and the Ministry of Maori Affairs for representation. The Ministry declined to be involved but in February 1992 Mina Timu Timu, from the Council of Maori Nurses, joined the National committee as our first Maori representative. At this time there was no collective Maori midwifery voice and the only related group were the Maori nurses. Mina was the only nurse and midwife on the Council. In later years, as the National Committee gained a greater understanding of biculturalism, Mina's position evolved to that of Kuia or Elder. Joan and Mina modelled this bicultural partnership for the College.

Other Transitions

As well as the Midwifery Policy Statement (NZNA, 1989), there were two other major activities with which the National Midwives Section was involved that were transferred to

[6] Maternity Action Alliance: Celia Grigg Sowman; La Leche League: Marcia Annandale; Parents Centre NZ: Sharron Cole. Parents Centre funded all of Sharron's costs as a demonstration of its support for the College.

and continued by the New Zealand College of Midwives. These were the development of Midwifery Standards for Practice, Service and Education and midwifery involvement in the Department of Health Working Group on Safe Options for Low Risk Pregnancy. Both of these initiatives resulted in documents that were to become foundation documents for the College.

Midwifery Standards for Practice, Service and Education

The importance of professionalising midwifery was beginning to be understood by the Section in 1986. Prior to the Massey Midwifery Workshop the National Midwives Section had started to discuss the need for a Code of midwifery practice, similar to that of midwives in the United Kingdom. Because of our colonial history British midwives had always provided a professional role model for New Zealand, and indeed many New Zealand midwives were trained in Britain at that time. Our initial framework for midwifery standards was based on documents from Britain such as the United Kingdom Central Council (UKCC) Midwives Rules and Code of Practice (UKCC, 1985).

An initial workshop was held at the National Midwives Section conference in Christchurch in 1986, where draft philosophies prepared by Otago and Wellington Sections were tabled. Auckland Section had adopted the philosophy statement developed at the Massey Workshop and there was a desire to have a single philosophy statement for the Midwives Section. Over the next two years the National Committee held a series of one-day workshops after each of its regular meetings. Through these workshops a statement of philosophy and standards for practice, service and education were developed. Each draft went through an extensive consultation process in the regions. Sally was primarily responsible for the collation of various drafts of these standards. At its AGM in August 1990 the College formally adopted the Philosophy and Standards of Practice, Service and Education (NZCOM, 1990).

However, the process of standards development that began in 1986 continues to this day. Analysis of each version of the philosophy and standards reflects our development as a profession and our understanding of key principles for midwifery practice. For example, there was considerable debate about the philosophy statement. This centred on whether we should have a truly women-centred statement or one that diluted the focus on the woman to the baby and the family. In fact the first draft didn't even mention the word 'woman'. Rather we referred to 'clients' and there was one mention of 'women' in the plural (Midwives Section, 1989b).

The first agreed philosophy statement (accepted by the Midwives Section in 1989 and initially adopted by the College when it formed) had made some progress. While the statement still did not refer to the 'woman', the holistic and integrated nature of midwifery was identified and the midwife's responsibility to the baby's health was included. However, this was qualified by the words, *'enhancing the health status of the baby when the pregnancy is ongoing"* (NZNA, 1989, p.26), meaning that the midwife only had a responsibility to the baby once the woman had decided to proceed with the pregnancy. This was the end result of an often heated debate about the midwife's role in abortion.

Our emerging understanding of the women/midwife relationship is also reflected in the evolution of the philosophy statement. In the first statement we said that *'Midwifery care takes place in the context of mutual support. Clients play a role in shaping midwifery'* (NZNA, 1989, pp.8 & 26). By the second version in 1992 we replaced these words with *"midwifery care takes place in partnership with women. Continuity of midwifery care enhances and protects the normal process of childbirth"* (NZCOM, 1992a, p.2). The notion of partnership was to become the theoretical framework for midwifery practice in New Zealand (see chapter on partnership). It was not until 1992 that the profession as a whole was willing to accept notions of 'partnership' and 'continuity of care' as core components of midwifery practice. It must be remembered that most midwives at that time worked on rostered shifts in hospitals and most had never had the opportunity to experience or provide continuity of care or autonomous practice across the entire maternity experience.

There was need for extensive consultation and debate for midwives to understand the direction in which the profession was leading them. For most the debate was about a concept rather than the reality of their midwifery practice and it took some time to reach consensus. During that process midwives wanted to be more explicit about the nature of their practice and the sentence, *"Midwifery care is delivered in a manner that is flexible, creative; empowering and supportive"* was added in 1992 (NZCOM, 1992a, p.2). When we revised the philosophy again in 2002 we prioritised these partnership and continuity of care statements as the starting point of the philosophy rather than the end (NZCOM, 2002). Over these thirteen years we have moved from a theoretical base to a practice base in our philosophical understanding of midwifery as it is practised in New Zealand today.

The unique nature of midwifery practice in New Zealand has also meant that we have needed to modify the International Confederation of Midwives (ICM) Definition and Scope of Practice of a Midwife statement. In the early days we accepted this unquestioningly and we quoted the words *"on her own responsibility"* as evidence of the midwife's right to practice without the supervision of a doctor. By 2002 the evolutions and revolutions in midwifery practice meant that the ICM scope of practice statement could no longer be used to define New Zealand midwifery. It was completely rewritten to reflect the reality of midwifery practice in New Zealand and the consultation process for this new scope of practice statement was straightforward and without dissent. The new Scope of Practice statement read:

> *The midwife works in partnership with women on her own professional responsibility and accountability to give women the necessary support, care and advice during pregnancy, labour and the postpartum period, to facilitate births and to provide care for the newborn.*
>
> *The midwife promotes and supports the normal childbirth process, identifies complications in mother and baby, accesses appropriate medical assistance and implements emergency measures as necessary.*
>
> *Midwives have an important role in health and wellness promotion and education for the woman, her family and the community.*

> *Midwifery practice involves informing and preparing a woman and her family for pregnancy, birth, breastfeeding and parenthood and extends to certain areas of women's health, family planning and infant wellbeing. The midwife may practice in any setting including in the home, the community, hospitals, clinics, health units or in any other maternity service* (NZCOM, 2002, p.4).

The Handbook notes that the feminine gender in relation to the midwife includes masculine and the word 'woman' used throughout includes her baby/partner/family/whanau. The Scope of Practice statement in the Handbook for Practice was updated again in 2005 to reflect the Midwifery Council's definition (NZCOM, 2005).

The Standards also reflected our emerging understanding of midwifery as a relationship rather than a process. The early drafts and first agreed set of standards were based on the nursing process, which we modified to try and reflect midwifery's wellness and assessment focus rather than the problem-based approach of the Nursing Process[7].

By 1992 the profession was better able to articulate midwifery as separate from nursing and was developing its own professional frameworks rather than trying to adapt those of nursing. Our first 'Handbook for Practice' brought together the philosophy statement, the new standards (which by now had amalgamated the previous standards of practice, service and education), our first Code of Ethics, decision points for midwifery care (that were adapted from the Department of Health Discussion document on care for women in low-risk pregnancy), sketchy guidelines for referral and a complaints mechanism. The philosophy statement had been expanded to include the concepts of partnership and continuity of care. The post 1990 practice environment impacted on the way that midwives thought about their practice and the standards reflected our emerging understanding of accountability and responsibility now that midwives were able to practice without the supervision of a doctor. By 1992 the standards prioritised partnership between the woman and the midwife and reflected actual practice in a continuity of care model (NZCOM, 1992a).

A major step in the development of the first Handbook for Practice (1992) was a three-day NZCOM Education Workshop held at Victoria University in February 1992. There were 39 participants representing a wide cross section of midwives and consumers and the maternity services. Bronwyn Pelvin[8], who led the workshop on the Code of Ethics, later described the unique experience of this gathering in the College Journal. She said of the participants,

> *"There were midwives from all over New Zealand from all spheres of practice. Independent practitioners, some of them newly independent, some of them domiciliary midwives from way back; hospital midwives, some staff midwives some charge midwives; managers of maternity and obstetric units, mangers of services for Area health Boards; midwifery educators and new graduates. Joining us in our endeavours were two consumers representing La Leche League and the Homebirth*

[7] Some description of the nursing process.

[8] The International Confederation of Midwives was later to quote Bronwen Pelvin (1992) in its Code of Ethics publication (date). The quote said, *"find quote.*

Associations and representatives from the New Zealand Nurses Association and the Nursing Council (Pelvin, 1992, p.6).

The workshop was funded in part by the Department of Health's Workforce Development Fund, the NZCOM and the generosity of the participants themselves. The impetus for such a gathering came from the changes to midwifery services initiated by the Nurses Amendment Act 1990. It was seen as imperative that midwives took a proactive stance on issues that had arisen as a result of midwifery independence. The workshop was divided into several groups who worked on various topics and reported back to the whole group.

The topics were the Code of Ethics/Conduct, recommendations on service delivery and complaints mechanisms, guidelines for referral and decision points, a framework for midwifery education, and submissions on Vision 2000 and the review of the 1986 Obstetric Regulations (NZCOM, 1992b).

The documents produced at the workshop were circulated through the regions for consultation and the final documents were adopted when they were incorporated into the first Handbook for Practice in August 1992. One of the consumers, Judi Strid, led the development of the complaints mechanism that was incorporated into the Handbook. The recommendations on service delivery that arose at the education workshop formed the basis of later 'Position Statements' for the College. The pressing practice issues of the day were identified as artificial rupture of the membranes, routines suctioning of the newborn, meconium liquor, ultrasound, electronic fetal monitoring, induction of labour, vitamin K, ecbolics, episiotomy, second stage of labour, vaginal examinations, epidural and use of Pethidine. Depressingly many of these practice issues remain as much of a concern today as they were then.

Department of Health Discussion Paper

Another foundation document for the New Zealand College of Midwives was the *Discussion Paper on Care for Pregnancy and childbirth* produced in December 1989 by the Working Group on Safe Options for Low Risk Pregnancy (Working Group, 1989). This paper was to assist the Department of Health with the development of a national women's health policy for pregnancy and childbirth services. The document was developed under three headings: voice, choice and safe prospect. The Department of Health established two working groups; one group made up of midwives, doctors and consumers including both Maori and Pacific consumers concentrated on the sections on consumer 'voice' and 'choice'. The terms of reference for this group were to gain consensus on the way that women were consulted, involved and listened to in the implementation of maternity services by Area Health Boards. The membership of this group was diverse[9]. The second group was the technical group, which was charged with

[9] Elaine Annandale and Anna Bailey,Pacifica; Aroha Reriti-Crofts and Moana Sharland, Maori Women's Welfare League; Karen Eagles, Parents Centre New Zealand; Madeleine Gooda, Home Birth Association; Susan Morton, Wellington Maternity Action; Rukmini Venkataiah, Auckland Women's Health Council; Karen Guilliland and Sally Pairman, New Zealand College of Midwives; Bronwen Pelvin, Domiciliary Midwives Association; Helen Rodenburg, Royal New Zealand College of General Practitioners; Helen Sill, Royal New Zealand College of Obstetricians and Gynaecologists.

developing the section on 'safe prospect', ie. the consensus management of women's low-risk pregnancy and childbirth. The NZCOM 1989/90 Annual Report written by Karen as NZCOM President and a member of the Technical Group records that,

> *our terms of reference were originally to identify a risk list, that is women who would not qualify for midwifery care but who would require medical supervision. Such a list however was to be elusive since there was little evidence to support many of the old risk assumption. We finally developed decision points in pregnancy where we identified options available to both women and their care providers* (NZCOM, 1990, p. 2-3).

In effect the technical group developed practice guidelines for all health practitioners providing maternity care. Members of this group included obstetricians, general practitioners, midwives and a physician.[10] The convenor for both groups was Pauline Barnett, Health Planning and Research Unit. The Department of Health Advisors were Gillian Durham, Principal Medical Officer and Paula McIver, Advisory Officer.

The technical group saw maternity care and antenatal care in particular as over serviced because it involved a fee-for-service payment for every visit regardless of need. They challenged the current routine of antenatal visits including the timing, the number of visits and the investigations done at each visit. The group said,

> *"Over servicing does not equate with good quality care, may medicalise pregnancy and cause the woman much anxiety. Unnecessary reliance of the woman on her health professional may be generated which may undermine her confidence in her self-care and her ability to assess her baby's wellbeing"* (Working Group, 1989, p.40).

The group proposed an alternative model of maternity care based on assessments at critical points of pregnancy, labour, birth and the postpartum period. The critical points were the minium number of time when it was considered there ought to be an assessment. These decision points identified the information required at each assessment in order to decide whether additional care was required. It is worth noting that this document was the first time since the 1920s that the Department of Health publicly defined pregnancy as a normal process.

Many of the members of the consumer voice and choice group were very sympathetic to the expansion of the autonomous midwifery role and to home birth. The resulting document supported these and other principles of women centred care such as continuity of care, women-held notes and informed choice and consent.

The final document made a number of recommendations including, planned early discharge, antenatal education as a basic right, ten days of postnatal care, review of payment for domiciliary midwives, retention and establishment of small rural birthing units, direct entry midwifery, and access to hospital beds for independent midwives. The working group also recommended the disbanding of the Obstetric Standards Review

[10] General Practitioners Tony Birch and Michael Kerr; Hospital physician Ray Naden; midwives Joan Donley and Karen Guilliland; Obstetricians Professor Richard Seddon and Helen Sill.

Committees. These committees, made up primarily of obstetricians, had for many years dominated the maternity services, driving practice and creating a significant barrier to midwifery-led care.

While the New Zealand College of Midwives greeted the document with enthusiasm, the medical profession were largely opposed to its recommendations. The Department of Health was unwilling to antagonise the medical profession and consequently decided not to officially publish the document. However, the process of consultation and consumer involvement through nine drafts in order to reach consensus exposed the Department of Health to the possibilities of midwifery-led care. The document was used by the Department as a reference in the drafting of the Nurses Amendment Act 1990 and other associated legislation, legitimising autonomous midwifery practice. Many of the principles within the document were picked up later in the drafting of the Section 51 (later Section 88) Advice Notice that established the framework for an integrated maternity service in which midwifery-led care plays an essential role.

Conclusion

Finding a place to end discussion on the development of the College is somewhat arbitrary because its establishment involved so many aspects of transition. Moving midwifery from its historical position as a branch of nursing, to a separate self-determined midwifery profession was extremely complex and took place over decades. Midwives increasingly became aware that they did not 'fit' with nursing and that they needed to be able to speak for themselves. The formation of the College was the culmination of years of frustration with the Nurses Association and its inability to recognise the different needs of midwifery. At the same time women were expressing their frustration with a maternity service that was not meeting their needs. It was inevitable that midwives and women would join forces in order to shape a different maternity service. One shared strategy for this was the need for midwifery autonomy. The formation of the New Zealand College of Midwives was a necessary step towards this goal because it provided both the vision and the voice for women and midwives to achieve this change.

The work of the Midwives Section was the foundation from which the College of Midwives evolved. However, once it was formed the College rapidly assumed its leadership role and over the next decade established and positioned midwifery in partnership with women as the primary provider of maternity services in New Zealand.

The major factor in the success of the College in developing and consolidating this new midwifery profession was the enactment of the Nurses Amendment Act in 1990 that enabled midwives to practice independently and without supervision from doctors. Without the ability for midwives to practice autonomously it is doubtful that the New Zealand College of Midwives would have evolved in the way that it has. The formation of the New Zealand College of Midwives together with the passing of the Nurses Amendment Act was critical to the development of the women-centred maternity service New Zealand enjoys today.

Professional development is the mechanism the College has used, and continues to use, to educate and support midwives to take on the professional role that automatically

accompanies autonomous clinical judgement. This professional development framework consists of articulating the underlying philosophy and code of ethics, describing the scope of practice, setting the standards, developing educational programmes, developing practice guidelines and consensus statements and encouraging evidence based practice. The Midwifery Standards Review process enables each midwife to measure and evaluate herself against this professional framework. The beginning development of this framework has been discussed in this chapter. Midwifery Standards Review forms an integral part and is discussed fully in chapter five, as is the resolutions process for consumers.

References

Board of Management. (1989a). *Treasurer's Report AGM 2nd April 1989.* Unpublished.

Board of Management. (1989b). *Board of Management Diary.* Unpublished.

Donley, J. (1986). *Save the midwife.* Auckland. New Women's Press Ltd.

Donley, J. (1988a) *Midwives or Moa.* Annual Midwives Conference address 1988, unpublished.

Donley, J. (1988b) *Aotearoa College of Midwives: Report of the working party. 3rd September 1988.* Unpublished.

Donley, J. (1988c). *Aotearoa College of Midwives: Report of the working party. 9th October 1988.* Unpublished.

National Midwives Section. (1986) *Minutes of Annual General Meeting 9/4/86.* Unpublished.

National Midwives Section (1987a). *Submission on future of midwifery education in New Zealand.* Unpublished.

National Midwives Section. (1987b). *Minutes of Annual General Meeting 23/9/87.* Unpublished.

National Midwives Section (1988a). *Minutes of National Midwives Section meeting 4/8/88.* Unpublished.

National Midwives Section (1988b). *Statement to NZNA Special AGM, April 1988.* Unpublished.

National Midwives Section (1988c). *Paper on Midwifery Representation Choices, July 1988.* Unpublished.

New Zealand College of Midwives. (1989a). *Minutes of Annual General Meeting 2nd April 1989.* Unpublished.

New Zealand College of Midwives. (1989b). Unpublished draft documents.

New Zealand College of Midwives (1990). *Annual Report 1989/1990.* Unpublished.

New Zealand College of Midwives. (1990). *Minutes of Annual General Meeting 1990.* Unpublished.

New Zealand College of Midwives (1992a). *Midwives Handbook for Practice,* Unpublished.

New Zealand College of Midwives (1992b). *Report of NZCOM Education Workshop, Wellington, 1992.* Unpublished.

New Zealand College of Midwives (2002). *Midwives Handbook for Practice,* Dunedin: Author.

New Zealand College of Midwives (2005). *Midwives Handbook for Practice,* Christchurch: Author.

New Zealand Nurses Association. (1981). *Policy statement on maternal and infant nursing.* Wellington: Author.

New Zealand Nurses Association. (1984). *Nursing education in New Zealand. A review and a statement of policy.* Wellington: Author.

New Zealand Nurses Association. (1987a). *An evaluation of the Advanced diploma in Nursing courses (Department of Education). What is to be done? NZNA comments on the report.* Unpublished paper.

New Zealand Nurses Association. (1987b). *Annual Report 1987.* Unpublished.

New Zealand Nurses Association. (1988a). *Annual Report 1988.* Unpublished.

New Zealand Nurses Association. (1988b). *Towards a corporate plan for NZNA,* Wellingon: Author.

New Zealand Nurses Association. (1989). *Midwifery Policy Statement.* Wellington: Author.

Pelvin, B. (1992) Current ethical considerations. *New Zealand College of Midwives Journal, 7,* 6-9.

United Kingdom Central Council. (1985). *Midwives' Rules and Code of Practice.* London: Author.

Working Group on Safe Options for Low Risk Pregnancy. (1989). *Discussion Paper on Care for Pregnancy and childbirth* produced in December 1989 by the Working Group on Safe Options for Low Risk Pregnancy, Wellington: Department of Health.

Pairman. S. & Guilliland, K. (forthcoming). NZCOM: the evolution of a professional organisation. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

[Note this is an unedited version prior to publication and changes may be made as a result of the editorial process]

Chapter Five NZCOM – the Evolution of a professional organisation

This chapter discusses the evolution of the College from 1990 to 2005. Rather than try to explain this evolution chronologically, we have identified a number of key developments that have contributed to the structure and function of the College that we have today. We also try to identify the underlying philosophy and strategy that drove these developments. It is the amalgamation and integration of these developments that has consolidated midwifery as a profession under the New Zealand College of Midwives and established midwives as the key providers of maternity services in New Zealand over this time.

Structure

The key driver in the evolution of the New Zealand College of Midwives is the sustainability of the profession and its ability to provide women-centred care. The College has always understood the need to create an organisational structure that ensures the survival of the College as a dedicated professional organisation for midwives. Analysis of professional organisations in New Zealand and overseas demonstrated that separation of industrial and professional interests had to be managed carefully or one had the potential to overwhelm the other to the detriment of both and the overall profession. With a small midwifery workforce of about 2500 practising midwives it has been important not to create a variety of separate midwifery organisations to manage the myriad of midwifery interests and issues. In order for a professional organisation to meet the needs of its individual members as well as the wider profession, it must balance the tension between collective professionalism and the individual's personal and pecuniary interests.

Collectivism has always been the underlying philosophy of the College and therefore it has worked hard to ensure that the different needs of midwives and midwifery groups can all be acknowledged and respected within an integrated framework. Midwifery is now the key provider group in maternity service provision in New Zealand. Some 78% of women have a midwife as their lead maternity carer (LMC) so sustainability is essential to the health system. A little over half of the midwifery workforce is employed (some as LMCs and the majority as core or essential hospital service midwives) and the rest are self-employed as LMC's providing both a primary and secondary maternity service across the community and hospital sector. Internationally this is the unique feature of the New Zealand midwifery workforce as in most western countries, outside the Netherlands; midwives are employed and mostly hospital-based. Therefore New Zealand midwifery requires a unique structure to support it. The structure of the College in 2005 reflects the interests of both the

individual midwife and the collective profession, industrially and professionally under the one umbrella.

Current structure of the New Zealand College of Midwives

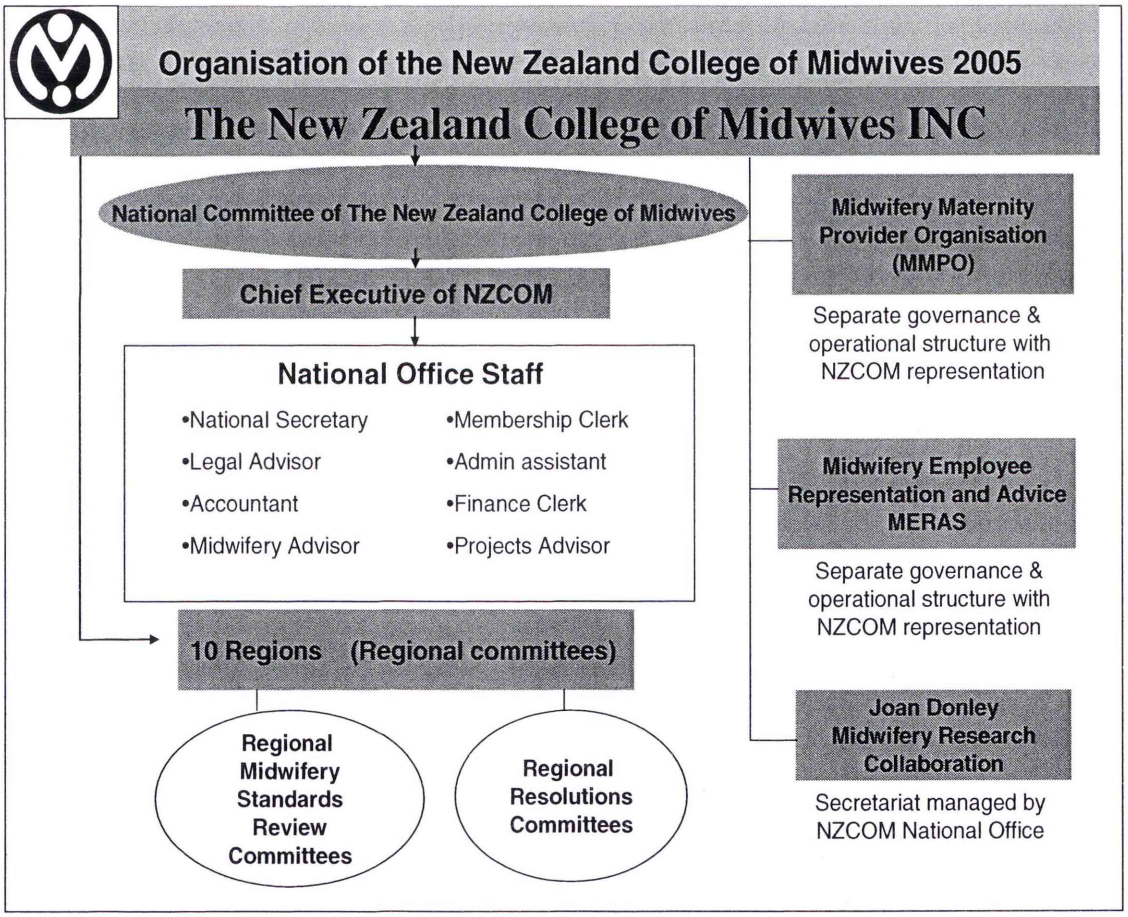
The College's primary role is as the professional organisation. It sets and actively promotes high standards for midwifery practice and assists midwives to meet these through involvement in midwifery education and quality assurance processes. The College represents midwifery and women's health interests to government, health organisations, consumer groups and the general public. Professionalism is conceptualised within this structure as a partnership between midwives and women. Professionalism requires high standards of education and research and accountability to women. The processes to achieve this have been developed by the College and they include Midwifery Standards Review, Resolutions Committees, and professional advice and representation. At the same time the midwifery workforce requires support that is effective and responsive to its needs.

As described in the previous chapter, the College has a regional and national structure. New Zealand is divided geographically into 10 regions, each with its own regional committee and chairperson. Each region works autonomously and chooses whether it has its own constitution or operates under the national constitution. Each region has standing committees; one for operating the Midwifery Standards Review process and one for the resolutions committee process. These committees are vital to the College's ability to work in partnership with women to ensure that standards of midwifery practice are maintained and promoted. This commitment to professional standards meets midwifery's obligation to the women who use its services and provides the necessary support for midwives to achieve the standards as well as providing a risk management framework for the College's professional indemnity strategy. Midwifery Standards Review and the resolutions processes are discussed in more detail in chapter X.

The ten regional chair people make up the National Committee along with three consumer representatives, two student representatives, two representatives from Nga Maia o Aotearoa me te Waipounamu (Maori Midwives Collective), the President and the CEO. Currently appointed as co-opted members to the National Committee are Joan Donley and Mina Timu Timu, Elder and Kaumatua respectively, and Jackie Gunn as the Education Consultant. Sally Pairman was the College's first Education Consultant (a position established following the end of her term as President) but she stood down in 2004 when she took on the role of Chair of the Midwifery Council. The National Committee meets three times a year as the decision-making body. It uses consultation and consensus decision-making processes to ensure that the region's views are represented and as many midwives as possible are involved in decisions. The way the College operates has been a conscious endeavour to ensure that all aspects of the College's person power and structure work in partnership together at a governance and operational level.

The National Committee employs the CEO, who in turn employs the staff of the National Office. Their role is to support the regions and to manage the day-today activities of the College. This will be discussed in more depth later in the chapter.

The following diagram illustrates the interdependent relationship of the College to its other separate arms – the Midwifery and Maternity Provider Organisation (MMPO), Midwifery Employee representation and Advisory service (MERAS) and the Joan Donley Midwifery Research Collaboration (JDMRC). With the exception of the JDMRC, each organisation has a separate governance structure and defined role and function. However membership of the MMPO and MERAS is only open to midwives who are also members of the College. The rationale for requiring midwives to be College members before having access to the services of the MMPO and MERAS is to ensure the collective involvement of midwives within the profession and to prevent duplication of roles within each arm and avoids one function overwhelming or taking precedence over another. The College itself is linked to both through representation on the governing structures of what are, in effect, the College's industrial and business arms. The structure allows each arm including the College, to have a core function and concentrate on that core function while still maintaining an integrated profession.



The Midwifery and Maternity Provider Organisation (MMPO)
In development since 1995 and registered as a limited liability company in 1997, the Midwifery and Maternity Provider Organisation provides a practice management system for individual midwives working with the case-loading model of care. These midwives are predominantly self-employed and running their own small businesses, providing

community based midwifery services, funded by the State's maternity benefit schedule. The MMPO provides the mechanism for midwives to access payment from this state maternity funding. Increasingly District Health Board employers of midwives with caseloads, particularly primary maternity units and small hospitals, are accessing the MMPO's systems for claiming payments for their midwives.

The MMPO's practice management system is centred on a standardised set of maternity notes that serve six main purposes. The notes provide professional documentation of services provided to women as required by statute; they provide women with a record of their entire maternity experience; they provide the claiming system for midwives to be paid for the service and for the state to audit midwifery service provision; and they are a nationally standardised data collection tool for maternity outcomes which contribute both to the national Maternal and Newborn Information Database as well as providing individual midwives with their annual record of birth outcome statistics for Midwifery Standards Review. The maternity notes contribute to the integration of each woman's care as they are held by the woman and shared with each provider regardless of who they are. Each provider can document in the notes so the entire record is maintained in one place.

The Midwifery Employee Representation and Advisory Service (MERAS)
Established in 2002 as the last piece of the structural jigsaw puzzle that makes up the midwifery profession in New Zealand, the Midwifery Employee Representation and Advisory Service (MERAS) provides services to employed midwives who predominantly provide core midwifery services within primary, secondary and tertiary maternity hospitals. In establishing MERAS the vision was to negotiate a national employee collective agreement specific to midwifery that enhances and protects midwifery practice within these settings. Still in its early days, MERAS provides a mechanism through which all employed midwives, who choose to join, can be employed under the same terms and conditions no matter where they work. This single collective agreement provided an opportunity to develop an innovative employment agreement that integrated professional development within the overall agreement and within its payment scales.

Until 2002 employed midwives had no option but to be recognised under variances in the nurses' employment agreements. These were based on the needs of the nursing workforce whose numbers far exceeded those of midwives and whose practice was much more diverse. The focus in 2004 was on building membership of MERAS and developing the collective agreement. The philosophy was again one of partnership and negotiation through shared understanding and meaning, rather than through confrontation and adversity. It is a joint venture from the beginning between MERAS, employed midwives and DHB employers. The agreement aims were to meet the needs of women consumers by reinforcing holistic midwifery care, enabling midwifery autonomy and partnership with women and promoting midwifery within its full scope of practice within an employed setting. The motivation was to build an entire structure around employed midwives that promotes women-centred care and professionalism in the same way that Section 88 does for self-employed midwives. In February 2005 the multi- employer collective agreement became a reality and took its place as another historic achievement for the profession.

Joan Donley Midwifery Research Collaboration
In development since 1998 and finally established in 2001, the Joan Donley Midwifery Research Collaboration (JDMRC) is the evidence or research arm of the College. Its core purpose is to promote the provision and development of an evidence base for midwifery. It provides a mechanism for collaboration between researchers, midwifery educators, schools of midwifery, universities, hospitals, District Health Boards and the profession to evaluate and research the effectiveness and appropriateness of midwifery practice and policy. The College currently administers the JDMRC although there remains the potential for separate governance.

The College, the MMPO and MERAS are all governed and operated separately from each other. However, each aspect of this professional structure is linked to the collective vision for midwifery and maternity services through membership of the New Zealand College of Midwives. Requiring membership of the College in order to access the MMPO or MERAS is a deliberate quality assurance strategy in that it requires the individual midwife to meet the collective standards of the profession. This requirement protects the standard of care that the public can expect from a midwife and prevents the fragmentation of midwifery into a number of separate organisations, each with different standards. The College believes that its current structure provides the complete support system necessary to enable its midwife members to provide the standard of midwifery care expected by the public. Getting to this point has been the result of several changes over the years in anticipation and response to contextual changes that have impacted on the midwifery profession.

Initial funding
When the College was formed in 1989 it was a purely voluntary organisation comprising of the 10 regions and three consumer representatives loosely organised and with little funding and little capacity to pay for administrative support. With the passing of the Nurses Amendment Act in 1990 Helen Clark advised the College to apply for a Workforce Development Grant from the Department of Health. In October 1990 the College was granted a total of $76900 for three initiatives. These included $50,000 for an educator to run a series of seminars throughout New Zealand to educate midwives, hospitals and other health professional groups about the midwifery model of care and the implications of the Nurses Amendment Act 1990. Of this, $20,000 was paid to the educator and the rest was used for travel expenses, some secretarial services and the establishment of an office base. Some monies were accrued to ensure the College's continuing ability to employ the educator the following year. The second grant was for $14,200 to undertake research into midwifery education needs for midwives practising under the new Act. The third grant of $12,700 was a bicultural grant to increase Maori and Pacific Island women's awareness of midwifery as a profession and promote culturally safe practice amongst the midwives of Aotearoa.

Beryl Davies from the Wellington Region put together the grant applications and their approval by Helen Clark was one of the last actions by the outgoing Labour Government. Beryl also organised the ongoing administration of the research and bicultural grants. Contracting and administering contracts was a new experience for everyone and Beryl Davies took on this task with real commitment. The education grant provided an important

financial foundation for the College structure and it is difficult to see how we would have been able to develop so successfully in such a short a time without it.

Educator Grant

The College used this fund to employ Karen Guilliland as a part-time educator. At the time Karen was on a year's leave from her position at the Christchurch Polytechnic as a women's health lecturer, and was working for the New Zealand Nurses Union (NZNU) as a Professional Advisor and Field Officer. Whilst the Midwives Section and then the College membership were enthusiastic and committed, none of us had the depth of knowledge or experience necessary to ensure that this new specific midwifery organisation could reach its full potential. Karen had anticipated the need for the College to develop some legal and contractual knowledge once the Nurses Amendment Act had passed and she took this opportunity to learn in this new role. Stephanie Breen, Executive Director of NZNU, herself a midwife, willingly shared her experience in setting up a new organisation and became Karen's mentor, as did Trish Mullins, Legal Officer for NZNU. Eventually Karen resigned from the Polytechnic and remained employed by NZNU for 18 months, before resigning to take up the educator position for the College of Midwives (find section Karen wrote for NZNU about her experiences). To the outsider, that the President of the NZCOM was a Field Officer for the NZNU must have looked strange. However, it was a well thought out strategy and this invaluable experience greatly benefited both Karen and the College as the College developed its own structures and function to organise the midwifery profession.

The Workforce Development Grant (small though it was) enabled Karen to resign from the Nurses Union and take up the position of Educator in February 1991. In her Annual report of August 1991 Karen records that her role as educator had been a character building experience and that midwifery had a lot of work to do before there was any real understanding about midwifery philosophy and practice amongst non-midwives (NZCOM 1991a). During the seminars she delivered there were frequent attacks that were hostile and personal, mostly from the medical profession and hospital management. The resistance was not only to midwifery and the right of a midwife to be paid the same as doctors for the provision of the same primary maternity service, but also to the concept that a woman might be able to make decisions about whom she chose as her own caregiver. If Karen had not had a strong sense of self and unconditional support from her husband, family and friends this experience could well have ended her involvement in midwifery. In fact these experiences strengthened her resolve for justice for both women and midwifery. It was not only doctors and hospital managers that struggled with the pay equity and choice issues. Over the next few years the media, press, radio and television were relentless in the amount of air space they gave to the complaints of medicine over midwifery pay rates and Karen was constantly called to defend the pay equity and choice principles involved.

While the spotlight was tough there was a significant group of midwives throughout New Zealand who constantly supported Karen and the College and increasingly these midwives took up the media battles in their own regions. As well there were a large number of midwives who quietly advocated for and supported those of us who took on a public role for the College. This supportive environment was also the impetus for Karen to take on the

educator and College roles (with the significant drops in salary[11]) as spokesperson and 'front woman' for what she then saw as a social movement rather than a career move.

Research grant
A research consultant was contracted by the College to undertake research into the educational needs of midwives that would provide a basis for the development for proposals about the future structure, content and quality of midwifery education in New Zealand. The study was conducted from mid-1991 to early 1992 and surveyed some midwife members of the College. The research was somewhat ambitious and consequently suffered from a lack of depth. There were issues with the methodology of the research, the analysis and reporting of findings and the original data was destroyed before the report was completed (NZCOM, 1992). As a result the end report was not particularly useful, but it did appear that midwives were generally satisfied with the level of education available to them.

On reflection the project was probably too ambitious and in fact came too late to influence the major decisions being taken on the direction of midwifery education. Perhaps its main contribution was its reinforcement of the direction midwifery education was moving, with its focus on direct entry midwifery, competency assessment and professional development of midwives.

Bicultural grant
The College was conscious that it had little connection with Maori and that there were very few Maori and Pacific Island midwives in New Zealand at the time. This grant was to assist the College to inform and increase awareness amongst Maori and Pacific Island communities about midwifery as a career. It was also to try and increase Pakeha midwives' understanding of biculturalism. The College approached the New Zealand Council of Maori Nurses for help in awarding this grant and as a result the Council of Maori Nurses agreed to nominate a Maori midwife onto the National Committee.

The utilisation of this grant was difficult because of the lack of Maori midwives to advise us or with the capacity to undertake the project on behalf of the College. It wasn't until 1994 that there was a national Maori midwives group and it was then that the College granted the money to Nga Maia o Aotearoa me te Waipounamu (Maori Midwives Collective) to administer.

Restructuring of the College and constitutional changes
The initial structure of the College has remained largely intact but with some refinements over the years. The first and most significant change was the move from a totally voluntary structure to one that incorporated some paid positions. The initial Board of Management

[11] The summary of the NZCOM National Committee meeting of 15 February 1992, written by Julie Richards, noted that by accepting the midwifery educator position, Karen's salary had now been halved. The National Committee agreed to review this at the AGM in August 1992 (Richards, 1992).

moved from Christchurch to Wellington[12] by August 1990. This move was because the first constitution encouraged a rotating Board of Management. The Annual General Meeting (AGM) in August 1990 also elected Karen Guilliland as President (unopposed) for another term. The same AGM added the President to the constitution and clarified how the President would be elected and the term of office. By the AGM in 1991 it was apparent that expecting a voluntary Board of Management to run the College was unrealistic, particularly when those Board members were all practising midwives. Another impetus for change was the need to negotiate and administer professional indemnity insurance for College members (see below).

Accordingly the AGM in August 1991 passed remits requiring the National Committee to develop a plan for restructuring that could be implemented following a Special General Meeting to approve the changes. Members were consulted through the newsletter and regional meetings on a proposal for restructuring which introduced a 24 hr/wk paid position for a National Coordinator to the Board of Management. The Board of Management (BOM) would reduce from six to three with the National Coordinator taking one of these positions as of right. The whole BOM would be part of the national committee so that governance belonged with the combined group. The constitution would be amended to include a representative from Maori on the National Committee. The first Maori representative was Mina Timu Timu, a midwife from Taranaki of Te Atiawa, and member of the Council of Maori Nurses. Mina has remained on the National Committee to this day, now as Kaumatua to the College. She has provided invaluable guidance and support as the College has worked to recognise the Treaty of Waitangi and develop its processes for partnership with Maori.

A Special General Meeting in February 1992 ratified the new structure and Karen Guilliland was appointed as the part-time National Coordinator. The BOM moved back to Christchurch, as it was more practical to base the BOM in Christchurch where Karen lived. Nor was there any offer from any other region to take on the BOM role. The new Board of Management in 1992[13] comprised three midwives with some secretarial and accountancy support. Karen's term as President finished in August 1992 and Sally Pairman was the next President elected unopposed. Karen was made an honorary life member on completion of her five-year term of office (three as the College President and two as the National Midwives Section Chairperson) in acknowledgement of her work. Karen continued in the position of National coordinator and in 1993 this position became full-time (on a salary of $32000). In 2005 Karen remains in this position although the role has had several name changes along the way, to National Director and then to Chief Executive Officer, titles that reflect the commercial market-oriented decade the College has had to work within.

[12] Lynley Davidson, Beryl Davies, Jeannie Douche, Christine Griffiths, Jennifer Sage and Chris Hannah, (later replaced by Marjorie Morgan) were the Wellington Board of Management from August 1990 to April 1992

[13] Karen Guilliland (Coordinator), Kathy Anderson (Treasurer), Karen Barnes (Newsletter Editor), Margaret Stacey (Secretary), Russell Foster (Accountant).

1992 / 1993

The next significant structural changes occurred at the AGM of August 1992. These consolidated the philosophical direction of the College. This was the year that consensus decision-making replaced votes, recognition was given to the Treaty of Waitangi and the promotion of biculturalism, midwifery was established as a partnership relationship between women and midwives, and continuity of care was documented as enhancing and protecting the normal processes of childbirth. This philosophical documentation was accompanied by remits, which called for the development of a standardised system for Midwifery Standards Review and the establishment of a system for the collection of standardised national midwifery statistics.

Further constitutional changes in 1993 strengthened the philosophical and quality assurance aspects of the constitution by spelling out the professional obligation of midwife members to *"have a responsibility to practise in accordance with the Standards and Code of Ethics set by the New Zealand College of Midwives"* (NZCOM, 1993). These changes demonstrated the College's commitment to developing a profession that practiced according to accepted and measurable standards. In the absence of a specific midwifery regulatory authority, the College assumed the role of standard setting and monitoring, even though it had no statutory power to enforce it. Legislation for all health professionals at that time only required payment of a fee for ongoing licensing and there was no requirement to demonstrate ongoing competency once registered. The priority given to the establishment of Midwifery Standards Review processes reflected the College's concern for professional responsibility and accountability (see below).

1994

By 1994 the National Committee was seriously concerned at the viability of its largely unpaid voluntary structure and the considerable workload of a National Office with only one fulltime paid employee. The rapid development of the College to a nationally and internationally recognised professional midwifery organisation and the concomitant rapid increase in market share for midwifery had stretched the College's resources to the limit. In March the College held a workshop run by Gill Down, an accountant with expertise in small business development, to review the management structure of the College. It was clear that there was a need to employ more staff; in particular an enlarged secretarial and administrative role was necessary.

For almost six years the National Coordinator had contracted in the secretarial services of Margaret Stacey, as there was not the funding security to employ another person. Margaret ran her own secretarial business and together with her husband Richard had become a staunch supporter of the midwifery cause, contributing hundreds of unpaid hours over those years. The 1994 fee increase in August provided enough funding to employ a secretary for the College at 30 hours per week. Judy Henderson took up this position.

Remits passed at the Annual General Meeting in 1994 included the direction for the National Committee to form a working party to investigate various models of representation and National Office staffing. In 1994 Kathy Anderson stood down as National Treasurer after six years in the position and Linda Collier replaced her. Kathy was the original National Midwives Section Treasurer and was the person who managed the

financial transition to the College of Midwives once the Section was closed down. It was thanks to Kathy that the College started life in the financial position that it did.

1996 / 1997
At its AGM in August 1996 the College required each region to form at least one Midwifery Standards Review Committee and one Resolutions Committee. These committees were added to the constitution as standing committees of the College (NZCOM, 1996).

The National Committee meeting held on Owae Marae in Waitara, Taranaki in March 1997 discussed a number of proposals for further restructuring of the College. This meeting identified the issues that the College must address and support. These included strengthening the regions, strengthening partnership with consumers and Nga Maia, recruiting and maintaining membership, maintaining financial viability and stability, reducing isolation of chair people and increasing regional and national networks and information.

These issues remain the work of the College today and highlight that getting the structure right is only one aspect of a successful organisation. Equally important is leadership, both regional and national, and a functioning, participating membership. The meeting recognised this by deciding not to restructure but instead changed the functional nature of the National Committee and agreed to employ more staff in the National Office. To build the supportive networking function of the 22-person National Committee, the meetings were changed from four two-day meetings to three three-day meetings. These longer meetings allowed more time for workshops to build skills for regional chair people and for reporting back and discussing regional issues and strategies.

As a consequence the AGM in July 1997 altered the structure of National Committee by dissolving the Board of Management, but retaining the National Director as a member of the National Committee. The responsibilities of the National Treasurer were devolved to the NZCOM accountant. Two student representatives were added and Maori midwife representation through Nga Maia was increased from one to two. The category of consumer members to the College was separated from the other two categories of 'associate' and affiliate' and given their own category 'consumers'. Consumers continue to have full voting rights.

There have been no further significant constitutional or structural changes to the College since 1997 and the National Committee and regions have consolidated to a workable structure that seems to meet both regional and national needs. The College has maintained its strong collective and consultative base and has continued to build both the College and the midwifery profession.

Presidents
The College has had four Presidents since its inception, each of whom has provided significant leadership, albeit with different styles and with different priorities that resulted from the varying contexts within which each worked for the College.

Karen was in office from 1989 to 1992 and her political and strategic direction was essential to the establishment of the College (and she has continued to provide this through her position as CEO). Sally Pairman took over in 1992 until 1997 and her focus was on developing professional and educational frameworks and the integration of these with the Section 51 Service Specifications. Sally's key contribution was in guiding the College towards sound educational programmes, both undergraduate and postgraduate, that would develop and maintain midwifery autonomy in all practice settings. When Sally's term as President finished she was appointed the Education Consultant to the College to continue this work. Sally is currently the inaugural Chair of the Midwifery Council of New Zealand.

Sandy Grey was President from 1997 to 2002. As a full-time practising self-employed urban midwife with a well-developed business sense, Sandy's main focus was clinical practice and autonomy. Sandy brought this midwifery practice perspective to all her activities as President. On completion of her term she was appointed as the International Confederation of Midwives (ICM) representative for the College and currently holds the position of Asia Pacific Regional Representative on the Executive of ICM.

Sue Bree was elected President in 2002. Once again the College has been fortunate to have a full-time practising midwife in this role. Sue is a self-employed rural midwife with a background in primary maternity unit experience. She also spent six years as a midwife member of the Nursing Council of New Zealand where she was convenor of the Preliminary Proceedings Committee (PPC) for five years. Sue is now a member of the first Midwifery Council.

In recognition of their leadership through years of tumultuous development and change, Karen, Sally and Sandy were all made honorary members of the College on completion of their terms of office. The College has endeavoured to continue to access the unique institutional knowledge of retiring presidents by keeping them involved in College activities.

Awards and recognition

When any new organisation is established it requires considerable commitment from its founding members. The College was always aware of the amount of time and energy midwives and consumers put towards establishing the College as a successful organisation and it has tried to acknowledge and record its appreciation of these people. The first members of the College in 1988 paid their money and contributed their time in order to begin the process of developing the College. These people were acknowledged as founding members and a special badge was produced for them.

Foundation office holders, who made outstanding contributions in the move from the National Midwives Section to the College, were given life membership in recognition. Kathy Anderson, National Treasurer for both organisation and Jackie Anderson, National Secretary for both organisations, received these awards.

Individual women and midwives have also been recognised for their contributions over these establishment years. Joan Donley was made the first honorary member of the College in 1990 in recognition of her political acumen and midwifery vision. Majet Pot, an

Auckland consumer, was recognised with life membership for her work on the development of Midwifery Standards Review. Bronwen Pelvin received life membership in 2002 for her work with the Domiciliary Midwifery Society and its integration into the College as well as her work with Midwifery Standards Review.

Non-members of the College who played a significant role in the College development have also been recognised as Honorary Midwives. These are, Helen Clark for her political support, Irihapeti Ramsden for her cultural safety guidance, and Alison Dixon for her support in establishing the first undergraduate midwifery degree programme.

The regions themselves also recognise their local members who contribute in a constant and committed way by conferring on them life and honorary membership of the region.

Two midwives have received community recognition for their contribution to New Zealand health services through their work in midwifery. Joan Donley was awarded the Order of the British Empire in 1990 and Karen Guilliland was awarded the 1990 Commemorative medal. In 2002 Karen was also made a Member of the New Zealand Order of Merit.

Fee increases

Fee increases for College membership have been the only sources of funding available and were steadily increased over the years to support the ever-increasing activities of the College. The fee increases in 1994 differentiated between self-employed midwives and employed midwives in order to recognise that indemnity insurance was primarily for self-employed midwives, as many employed midwives continued to obtain indemnity cover through membership of NZNA and NZNU. The large fee increase was probably the first time that income matched the activities of the College. It was also the first time that some members (Treasurer, Journal Editor and Newsletter Editor) were acknowledged for their work through honoraria and payment of some expenses. The President did not receive an honorarium until 1995. And it was not until 2001 that the College could pay for hotel accommodation, full travel costs, reimburse full expenses and employ sufficient staff to manage the workload and activities of the College. In the early days we spent much time being billeted, paying for one airfare and trying to fit several activities into very long days to make the most of this, catching rides in other's taxis and generally trying to restrict any unnecessary spending. The membership fee has always been shared with the regions on a capitation basis as a way of funding regional activities.

Membership fees

Year	Full membership	Self-employed midwife members	Employed midwife members	Consumer members
1989	$52			$26
1991	$74			$37
1992	$120			$25
1993	$155			$30
1994		$255	$155	$30
1995		$350	$175	$30

1996		$630	$315 (same as NZNO fees that year)	$54
1999		$695	$345	$30

National Office staff

Karen continued to run the National Office virtually single-handedly with the part-time support of the National Treasurer and secretary who held voluntary positions. It got to the point that Karen could not take leave as there was no one in the office to cover for her. The first attempt to address this came with the employment of Linda Collier in 1995 for 24 hours per week on a one-year contract as Quality Assurance Coordinator (NZCOM, 1994). This position was intended to assist Karen through responsibility for providing resources and support to Midwifery Standards Review Committees and Resolutions Committees. However, it was difficult to progress these committees without a robust membership database and a system to record and maintain the funding base of subscriptions.

Membership database

The membership database began life on a home computer in Kathy Anderson's bedroom that no one knew how to use. Kathy hired a local university student to set up the database on the computer. By 1994 the national office had become more computer literate and Karen's husband Tony introduced and supported the office to install the student file system he used in the school in which he worked. The system called MUSAC, operated out of Massey University and became the College's foundation computer programme.

Marita Parini, a Christchurch consumer and ex midwifery client, had been doing some voluntary filing work in the National Office and she was hired on a part-time basis to assist Linda to organise an accounting and invoicing systems for the regions using the MUSAC database. At that time subscriptions were collected and paid regionally. The regions then capitated funds to the National Office. It became clear once the new database was installed that it would be more cost-effective to reverse this and have midwives pay membership centrally and then for funds to be capitated back to the regions.

In 1997 Rebecca Rayner was employed full time to facilitate this and she, together with accountant Cameron Wray (working 2 hours/week in 1997), steered the College though the computerisation of accounting and membership systems and the centralisation of membership subscriptions. MUSAC is unrecognisable in its original form, as it has been modified extensively to meet the needs of a vastly increased membership with a multitude of added functions.

By 2002, managing the membership database had become a full time job and the finance function was separated and managed as a half time position. This coincided with Rebecca going on maternity leave and returning to the finance role part-time. Edith Allen is now the membership clerk. The position now requires considerable computer skill and as Edith had worked in schools with MUSAC she has been instrumental in developing the latest updates which strengthen the ability of the national office to communicate and support the regions in the management of their members. By 2005 the business of running the College has escalated and Janet Ballard is the first full-time Finance Clerk.

National Office Staffing 1995 to 2004

Legal Advisor
The management of the professional indemnity policy (see below) and the defence of midwives in various disciplinary forums became increasingly complex and by 1995 Karen was feeling her lack of legal training. In December 1995 Jackie Pearse, midwife and newly qualified lawyer with a background in teaching, was appointed as the College's Legal Advisor.

With Jackie's appointment Karen was able to hand over the representation of midwives in various disciplinary forums (such as Accident Compensation Commission, Preliminary Proceedings Committee, Nursing Council, Coroner's Court and hospitals) that she had been doing until that point.

Karen had recognised that the College would need a dedicated legal advisor, as once the first Health and Disability Commissioner (Robyn Stent) was appointed by Government in 1996, the workload for the College was expected to increase. This was indeed the case and in her annual report of 1996 President Sally Pairman recorded that over the first 10 months of Jackie's employment there was a 300% increase in claims against midwives in a variety of forums (NZCOM, 1996).

This increase in complaints reflected the context of the time where the public, through the ACC Medical Misadventure processes and the Health and Disability Code of Consumer Rights, were more aware of their rights in relation to standards of health care and had clearer processes for complaint through the Health and Disability Commissioners Office. All health professionals faced similar increases in complaints as a result of this consumer rights legislation.

As well as representing individual midwives, Jackie Pearse played a significant part in helping to form and shape the College's frameworks and responses to medico-legal and ethical issues. For most midwives the establishment of the Health and Disability processes in those years made the concept of professional accountability a reality. They could see that midwives really were answerable for their practice decisions and Jackie was an essential element to midwives coming to understand their professional responsibilities to women as well as the wider profession.

Midwifery Advisors
The increased workload for the legal advisors was also repeated elsewhere in the College. The College needed to strengthen its proactive role in providing midwifery practice advice to midwife members. Many of the situations midwives found themselves to be in could be resolved if they were supported to address issues as they arose. Bronwen Pelvin was appointed in a part-time position in 1997 as a Midwifery Adviser to members. Her role was to help strengthen regional activity and act as an additional liaison and support person for the regional chairpersons and the national committee. Bronwen already provided training workshops for the Midwifery Standards Review Committees and on her resignation for health reasons in 1999 she has continued to run these workshops. Norma Campbell was

appointed in 2000 to build the Midwifery Adviser role further and to specifically develop networks for core midwives in order to improve the interface between hospital-employed midwives and midwives who were Lead Maternity Caregivers (LMC's). Alison Eddy, a midwife who had worked for the Ministry of Health, was employed in 2002 to manage various contracts and projects. The other mechanism for managing the workload has been to access specific expertise on short-term contracts. In 2002 Sally Pairman was seconded from Otago Polytechnic for six months to work on various projects and in 2003 Sandy Grey spent four months working in the National Office to provide cover for staff leave. Jackie Gunn, Head of School of Midwifery at Auckland University of Technology, was seconded for two weeks in 2004 to develop strategic advise for the College on continuing education in relation to maintaining competence in practice.

National Office Premises
In its short history the College has had five premises to house its National Office. Each move was made to improve the economic position of the College with the long-term aim of owning its own building.

The first office was established with the help of the education grant. Karen utilised some of that money to rent space at 192 Manchester Street. The office was known as the Midwifery Resource Centre and was heavily subsidised by the Canterbury/West Coast midwives, who shared the premises and made it affordable. Christchurch homebirth midwives and some other independent midwives also paid to use one room as an antenatal clinic/education room. Consumer groups had free access to the rooms for their meetings. The midwives supplied all the furniture and there was tremendous good will and generosity to enable the establishment and maintenance of this first national office. Recognition must go to Julie Hasson (nee Richards) a member of the BOM, who begged, stole and borrowed furniture, equipment, and stationary and talked her mother into making the curtains and cushions. This supportive partnership between the National Office and the Canterbury midwives has continued to this day through four further moves to ever-larger premises.

This first office building was owned by a sports medical practice. When they saw what a successful drop-in centre it made they reclaimed the rooms for doctors and asked the College to move out. The second premises were just down the road at 183 Manchester Street. These rooms quickly became too small as more midwives wanted to practice out of the resource centre. Situated on the first floor it did not lend itself to expansion or to the drop-in function.

After a long search it was decided to take the risk of renting much bigger premises with a long-term lease. These premises were at 906 - 908 Columbo Street, opposite Christchurch Women's hospital. When renegotiations on the lease occurred the landlord signalled his intention to increase the rent. By then the Pegasus Medical Independent Practitioner Organisation had taken over all the other floors. We were sandwiched between doctors at a time when relationships between midwives and doctors were at an all time low. The College approached Pegasus with an offer to move if Pegasus would pay out the lease and contribute to our moving costs. This they agreed to do and we then had the equity to buy our own building. It had taken National Committee a long time to agree to own property but once committed they backed the project enthusiastically. We bought an old single story

house in Bealey Avenue, which we converted to offices. The Honourable Helen Clark, soon to be Prime Minister, opened it in November 1999. The Christchurch Mayor and Mayoress, many Members of Parliament, the National Committee and many midwives and women attended the opening. This building not only housed the National Office, but also the Canterbury West Coast Region, the Midwifery Resource Centre and the Midwifery and Maternity Provider Organisation. By then the Midwifery Resource Centre was itself an incorporated society of local midwives and it rented space from the College, as did the MMPO and the Canterbury region. This shared the burden of mortgage repayments and lessened the financial risk. In fact it cost the College less than when we were renting. It turned out to be an inspired buy, bought at the bottom of a property slump in a prime commercial position. This was fortunate because by the end of 2001 the College had won the Ministry of Health contract (see below) and the office was far too small.

The National Committee was really challenged when they saw the next proposed purchase. Karen's hobby had for years been renovating old houses and selling them at a profit. With this experienced eye she found an old villa around the corner in a state of massive disrepair but full of potential. Unfortunately Karen was one of the few who could see this potential and both the National Office staff and the National Committee required extensive persuasion to agree that this building was a 'bargain buy'. The entire office attended the auction to bid for the building (the third premises to be situated in Manchester Street). The Bealey Avenue house was sold at a profit and renovations commenced on the new building. The National Committee were rather concerned when they visited in early 2002 to find that it had no floors and the back had been completely demolished. However, many could see that it was a substantial future home for the College of Midwives and everyone was proud and delighted at its opening in November 2002. It was opened by Christchurch Mayor Gary Moore and blessed by Kaumatua Sandy Carr.

The College now owns a substantial inner city building freehold and has enough equity vested in it to make the College financially viable for many years.

Indemnity insurance

Prior to the Nurses Amendment Act 1990 indemnity insurance was not a pressing topic for midwives as most were employed and supervised in their practice. Whilst midwives had indemnity cover through their union membership, indemnity insurance was not an issue for most health professionals, other than private consultants, because there were few complaints made against health professionals. This changed after the National Women's Enquiry and the resultant consumer rights legislation that raised the public's awareness of their rights in relation to health care. By 1991, with the rapidly increasing number of self-employed midwives who needed indemnity insurance, the National Committee had decided to investigate obtaining professional indemnity insurance for College members and the decision to investigate indemnity insurance was ratified at the Annual General Meeting in 1991 (NZCOM,1991b). The NZNU were particularly helpful and provided legal advice to the College on contract for a year while Karen Guilliland negotiated indemnity insurance cover for College members through the same underwriters as were used by NZNU and NZNA. College members were able to obtain individual indemnity cover through NZNU or NZNA while this negotiation took place. Karen was successful in negotiating a very reasonably priced policy by 1992.

Until December 1995 Karen, as the only employee of the College, managed all claims made on the indemnity insurance policy. Initially as the College was setting up Kevin Clay, lawyer and husband of Christchurch midwife, Dianne, provided much of the College's legal advice on a voluntary basis. He was the natural choice to help mange indemnity cases when outside law firms were required, such as cases that went to the High Court. By 1995 the management of claims was becoming complex and required increasing assistance from outside legal firms. As a result the College decided to increase its membership fee to cover the employment of an in-house lawyer to manage the increasing legal work.

The College's first lawyer was Jackie Pearse and she was an essential part of the College's risk management strategy. This strategy was based on the integration of several quality assurance activities. These quality assurance activities included midwifery standards review, resolution committees, continuing education programmes and evidence–based practice guidelines and consensus statements. These activities, coupled with having an in-house lawyer enabled the College to keep insurance costs at a sustainable level. The emphasis the College has placed on developing an integrated structure to maintain professional standards has demonstrated to its professional indemnity insurers that these mechanisms can effectively reduce complaints and claims against the insurance policy. Thus the College has been successful in keeping indemnity insurance premiums at an affordable level for midwives. This combined with New Zealand's no-blame, non-litigious Accident Compensation Insurance makes the maternity services practice environment unique in the world.

External funding contracts

The College has always relied on membership fees as its funding base. As a large component of its work was around education, both of midwives and the public, it was appropriate to start looking for other ways to supplement its funding base. It has been successful in negotiating three contracts in recent years.

Smoking cessation in pregnancy

The first outside contract the College negotiated was a joint venture with Education for Change (a community based education provider) and the MMPO in 2000. This three-year contract with the Ministry of Health was to provide education for midwives in the provision of smoking cessation support for pregnant women. Part of the contract provided for payment to midwives to attend education sessions and this was the first time any external funds had been available to individual midwives for education purposes. The programme was developed and taught by Stephanie Cowan from Education for Change, promoted and marketed by New Zealand College of Midwives and administered by the MMPO. It is recognised internationally as an innovative and women-centred programme that has demonstrated significant decreases in smoking amongst pregnant women. The programme was an extremely valuable tool for learning by midwives, focusing as it does on support strategies for behavioural change, and with wide application to many aspects of midwifery practice. The contract was hugely successful and was renewed for a further three years.

Family violence education for midwives
The second education contract with the Ministry of Health was an education programme on screening for family violence. Like the smoking cessation contract, its focus was on providing midwives with educational frameworks. Midwives learned how to ask difficult questions of their clients and how to improve women's access to solutions and resources in relation to family violence. This contract has run successfully from 2002 and was renewed in 2005. The contract has provided a platform for the College to develop a closer strategic relationship with other professional groups and consumer groups, such as the National Collective of Independent Women's Refuges and Doctors Against Sexual Abuse.

Promotion and maintenance of midwifery standards
In 2002 the workload pressures had increased again and the College made submissions to the Ministry of Health on midwifery's behalf for financial resources. The College pointed out that other more established health professions had received considerable resources from government over the years to develop and maintain their workforce. When midwifery gained autonomy in 1990 there was no resource provided after the small workforce development grant to assist the College with managing the change in service delivery for maternity. The implications of midwifery autonomy were underestimated by the Ministry of Health and as women increasingly chose the midwifery option the College had to provide extensive support and direction to a profession that rapidly became the major provider of maternity services. The Ministry of Health Maternity Manager of the time, Barbara Brown, agreed that midwifery deserved at least a similar level of support as general practitioners and nurses had received. A contract was negotiated whereby the College would be funded to promote midwifery standards of care through the development of the Midwifery Standards Review processes and other educational and quality assurance activities. The first year of the 3-year contract gave retrospective recognition to all that the College had already achieved in developing a professional midwifery workforce. This funding enabled the College to increase its national office staff and provide resources to support and develop midwifery standards review processes.

Communication, participation and networking

Publications

Newsletter
Prior to the establishment of the College the Midwives Section had tendered to use the NZNA Nurses Journal to communicate with midwife members and in later years the Auckland Midwives Section had produced a "Midwives Quarterly" but it was published sporadically. From its inception the College was keen to communicate with its members in a manner that was accessible and personal. Such was the enthusiasm that the first newsletter, dated November 1988, was titled 'New Zealand College of Midwives Newsletter', even though the College did not officially exist until the first AGM in August 1989. We were so proud of these first home-produced newsletters, carefully typed on someone's computer with enthusiastic experimentation with all possible fonts. We thought the insertion of pictures was terribly clever and the newsletters were then photocopied and stapled by hand before being sent out to all members. It needs to be remembered that most of us were very unfamiliar with computers and that we could not afford regular secretarial

support until July 1992. However, the newsletters were consciously informal, using first names, talking inclusively in the first person and trying to ensure that midwives would want to read the newsletter because they saw themselves as part of the College and the wider midwifery movement.

Initially the newsletters were sent out every few months and they increasingly became a mechanism for the College to inform and educate members about practice issues. Articles of interest were copied into the newsletters, as were newspaper clippings and general news and events. This was not always entirely 'proper' as in our naivety it took us some time to realise the copyright issues. From February 1991 it also included the Domiciliary Midwives Society newsletter, a decision they took in May 1990 to demonstrate their unity with the College. Each Board of Management had an identified 'Newsletter Editor', who was responsible for collecting material and putting the newsletters together. All were practising midwives. The first editor was Julie Hasson (nee Richards, 1988 – August 1990), followed by Beryl Davies (October 1990 – March 1992), Karen Barnes (July 1992 – July 1994), and then Julie Richards again (August 1994 – March 1996). Barb Pullar took over in March 1996 and changed the look and format of the newsletter with the assistance of graphic designer, Kirsten Rabe. By this time the College understood the importance of presentation for the public face of the profession and had allocated an increased budget to the newsletter. In October 2000 the name of the newsletter was changed from 'National newsletter to 'Midwifery News' to better reflect the style and content of the publication. By this time midwives were writing articles and opinion pieces on practice and professional and political issues of the day specifically for the newsletter. Barb continued in the role until March 2002 when we engaged professional publishers for the newsletter. We now have a glossy, full-colour cover and professionally produced publication that is distributed to all members four times a year.

Journal

The proposal to produce a journal for the New Zealand College of Midwives came first from Helen Manoharan and Judy Hedwig, two midwives from Palmerston North. Helen and Judy made a formal presentation to the National Committee on April 1st 1989 seeking support for their plan to edit and publish a journal on behalf of the College. Helen and Judy were given approval to produce one journal and this was published in September 1989. There were a number of issues to clarify in relationship to 'ownership' of the Journal and the respective roles and responsibilities of the National Committee, Board of Management and Journal Editors. (NZCOM, 1989) In those early days none of us had expertise in publishing and the first Journal was an excellent beginning. Helen Manoharan was really ahead of her time and had many commercial, editorial and marketing skills that the rest of us did not recognise at the time. Not did we appreciate the complexities of producing such a publication. The fact that Helen persevered was a tribute to her dedication and her vision for the Journal. The College worked with Helen to develop policies and frameworks for the Journal that continues today. In particular policy has been developed around advertising, the editorial process and the overall presentation of the Journal. Some of the discussions over the years also reflect our emerging maturity as a profession. An example was the heated discussions over the first cover. Many midwives balked at the picture of a stylised naked pregnant woman on the cover. Some refused to buy it, as they considered it was demeaning to women but in fact only 18 months later a cover by the same artist depicting

several naked pregnant women raised no comment or objection. Today midwifery and midwives frequently use the naked womanly form to advertise their practices.

The first issue of the journal was followed by one more in 1990 and we then produced two issues each year. Helen continued as the Journal Editor for ten years, Gillian White edited two issues and an Editorial Board[14] based in Dunedin now produces the Journal. Over the years there have been a number of midwives involved in assisting the editors with peer review of submitted articles[15]. Attempts to maintain functioning review committees have had varied success over the years mainly because this was once again a voluntary activity to be fitted in amongst many other commitments. The role of the Journal has been to support New Zealand midwives to publish their research and academic writing by giving them a forum through which to share their ideas and findings. Over the years, as more midwives have engaged in postgraduate study and undertaken original research, the pool of potential contributors and reviewers has increased. Over thirteen years the Journal reflects the growth of an emerging midwifery research culture and traces the rapid development of New Zealand midwifery knowledge. In 2003 its status as a peer-reviewed journal has been recognised by its inclusion in the international CINAHL database. As with the newsletter, the format and presentation of the Journal has improved over the years as more resources have been made available. Graphic designer, Kirsten Rabe, has worked with us since 2000 to give the Journal a more professional look and we have contracted the publishing responsibilities to commercial publishers since 2001.

Breastfeeding Handbook

One of the early practice issues for the College was breastfeeding. The consumers had identified inconsistency of breastfeeding advice to women as a priority and wanted to develop a policy statement on breastfeeding. The National Committee held a breastfeeding protocol workshop on 4th May 1990 in Christchurch. Kathy Glass, Chairperson of Waikato/Taranaki Region and Maternity Manager of the Taranaki Area Health Board, provided her Board's midwifery-led breastfeeding protocol and this was used as a blueprint. It quickly became obvious that midwives and women required more information that could be provided by a protocol and the decision was made to produce a book on breastfeeding for midwives. Marcia Annandale (La Leche League consumer representative on National Committee) volunteered to convene a working group to write the book. This group was known as the 'Handbook Committee'.[16] The group worked extremely hard and a number of drafts were circulated through the College regions and the consumer groups for consultation. The Breastfeeding Handbook was finally published two years later and launched at the NZCOM National conference in August 1992. Karen recorded in her Annual Report of that year,

> *"The Breastfeeding Handbook has finally come to fruition this conference. From small beginnings it became clear that this would be a major publication to be viewed by many and it was important that we produce a quality research-based*

[14] Alison Stewart (Spokesperson), Deborah Davis, Jean Patterson and Sally Pairman (all based at Otago Polytechnic School of Midwifery) and Rhondda Davies (Dunedin-based independent midwife).

[15] Consistent reviewers in the early years were Cheyl Benn, Liz Smythe, Andrea Gilkison, Karen Guilliland, Gillian White, Marion Lovell (check with Helen), Sally Pairman

[16] Marcia Annadale, Consumer and Convener; Chrissy Fallow, Lynda Bailey, Gail Warwick (midwives).

document ... It is thanks to Marcia Annandale's dogged commitment that the project has come abut so successfully. She and the Handbook Committee have spent thousands of hours in collating, researching, letter writing and telephone conversations making sure this was a reliable resource" (NZCOM, 1992).

The College had raised funds to meet the costs of production and we were extremely proud of this first professionally published book. It remains a seminal text that is used by midwives, women and students throughout New Zealand. It is currently being updated for reprint.

Conferences and celebrations

The College has held national conferences every two years since its inception. The theme of each conference reflected the priorities of the time and each conference has helped to clarify and form a consensus view around the evolving profession. Conferences have been increasingly well attended and profitable and have provided additional funding to the College's activity. Each conference profit contributes funds to support the Direct Entry Education Fund that can be accessed by student midwives. Each conference runs back-to-back with the Home Birth Association's national conference or meeting.

The first conference was held in Dunedin in 1990 with the theme "Women in Partnership" and it celebrated the imminent passing of the Nurses Amendment Act and midwifery's development as a separate profession. The keynote speakers were Marsden Wagner (World Health Organisation) and Helen Clark (Minister of Health).

Wellington region hosted the second conference in 1992. Its theme was "Continuity, choice and challenge" with London based community midwife Alice Coyle and NZ domiciliary midwife Sian Burgess as keynote speakers. This conference was concerned with the relationship and roles of hospital based and continuity of care midwives and the challenge of providing women centred care.

The third conference was held in Rotorua in 1994. It was the first conference to be held on a marae and it addressed cultural safety through its theme "the culture of midwifery" Finding ways to understand and provide services to Maori women in a way that was culturally acceptable was the theme. Keynote speakers included Irihapeti Ramsden (Cultural Safety) and Caroline Flint (UK midwife).

The fourth conference was held in Christchurch in 1996. Its theme was "midwifery: the balance of intuition and research" and its keynote speakers included Barbara Katz Rothman (USA) and Professor Jill White (Victoria University). Midwifery was starting to address the issue of evidence-based care and build its academic culture.

Auckland region hosted the 1998 conference that celebrated ten years since the idea of the College was initiated and ten years since the Cartwright report on informed consent. The theme of this conference was "The journey from past to the future; a decade of change" The keynote speakers were Nicky Leap (UK independent midwife) and consumer advocate Beverly Beech (Association for Improvement of Maternity services, UK).Speakers identified the real challenges of providing continuity of midwife care even with supportive

legislation, when in the spotlight of the media and the constant medical resistance to change.

Hamilton region hosted the sixth national conference in 2000 with a strong bicultural and homebirth flavour. Themed "Seasons of renewal; A celebration of birth in Aotearoa" Its keynote speakers were author and publisher of USA Mothering magazine Peggy O'Mara and American midwife author Ina May Gaskin .Highly challenging in relation to midwifery's philosophy of partnership and commitment to bicultural practice the conference never the less confirmed midwifery's direction must be in partnership with both women and Maori. Another turning point at this conference was the exploration of hospital or core midwifery and it's partnership with case loading midwifery.

The conference returned to Dunedin in 2002 with a strong consumer focus. The theme this time was "Celebrating diversity within unity" and keynote speakers were UK obstetrician Wendy Savage and Dutch midwife and business woman Beatrice Smulders .The challenge was reducing interventions in childbirth and its participants demonstrated a maturity and solidarity regardless of place of work.

2003 saw the inaugural Joan Donley Midwifery Research Collaboration forum, held in Christchurch. The Collaborations intention in running this forum is to build researchers and make midwives feel confident about their work by providing an opportunity for them to present in a less formal environment and outside of the usual academic platforms. The forum is held biannually in the alternate years to the College conference.

The Christchurch forum attracted 160 midwives from around New Zealand and the Pacific. The Collaboration's Patron, Joan Donley, was unable to attend due to her ill health but her daughter, Dee Pigouney, spoke on her behalf during the opening ceremony. Many participants were undertaking research within the DHBs or personal areas of interest and others were engaged in research through postgraduate midwifery study. The majority of presenters were making their first public presentations. The forum purposely coincided with the Commonwealth Steering Committee for Nursing and Midwifery's Pacific regional workshops. This enabled the attendance of many Asia-Pacific midwives from Fiji, Samoa, the Cook Islands, Vanuatu, Malaysia, the Philippines and the United Kingdom and Australia.

In 2004 Midwifery celebrated a hundred years of midwifery regulation. The conference was rightly placed back in the government city of Wellington for midwives and women to celebrate their mutual histories. The conference theme was "The past our gateway to the future; celebrating hundred years of midwifery registration". This conference established what we hope is a new tradition of inviting a NZ speaker to give the opening oration, and Karen was the inaugural speaker. Other keynote speakers were Sally Pairman, midwife educator and Chair of Midwifery Council and UK Professor Soo Downe, midwife researcher. Midwife MP Steve Chadwick launched the new Midwifery Council amidst wonderful celebration and good cheer. With the emphasis on history this conference highlighted NZ midwives and their work. Their reflections on practice, research and education illustrated the growing maturity of midwifery and the continuing challenge of keeping birth normal.

Another major event in 2004 was the exhibition "BORN" celebrating a hundred years of midwifery. This unique exhibition, commissioned by NZCOM, was launched in Parliament on international midwives day by Minister of Health Annette King and had 200 invited guests. The exhibition consisted of a series of panels that used individual midwife stories both Maori and Pakeha, as representation of practice over the century. Accompanying the exhibition was the book 'BORN' that recorded the full midwifery interviews as depicted in the panels. Nga Maia intends to do a similar publication of its stories. Through 2004/5 the exhibition travelled throughout all major cities and many of the provincial centres. It was housed in a wide variety of forums, libraries, art galleries, civic offices, hospitals, polytechnics and shopping malls. It was very well attended by the public receiving considerable media coverage and fulfilled its purpose of informing the public and making midwifery visible. Its final role was to stand in the foyer for the opening of the new Christchurch Women's Hospital. Transcripts, tapes and photographs are stored in the National Archives and the panels at NZCOM head office. The Nga Maia panels have been returned to Nga Maia.

This panel installation was in itself an art piece carefully crafted by oral historian and filmmaker Helena Ogenoski-Coates and designers Mark MacIntyre and Karl Fountaine under the dedicated project management of midwife adviser Alison Eddy. It took over a year to produce and is the first time the College has ever taken on such an ambitious project. Alison not only managed the research and the day-to-day work she also raised the funds and sourced sponsors to pay for it. The stories around the transport sponsor Main Freight are hilarious as truck drivers around the country tried to come to terms with not only transporting art works, but also the subject material. Just the words childbirth and midwife seemed to conjure up all sorts of pictures for them!

At the same time Victoria University's Nursing and Midwifery Department lecturers Pamela Wood and midwife Joan Skinner, together with Wellington midwife Judy Stehr, collaborated with Archives NZ to put together an historical record of midwifery in NZ. This collection was a labour of love involving many hours work and was arranged around three themes. The first focused on the education and regulation of midwives. It was named "women of good character'. The second," a congenial occupation", looked at practice, and the third "a haven of peace, quiet and confidence' focussed on the place of birth. This exhibition ran at Archives NZ throughout 2004/5 and has also had excellent coverage and public attendances. It provided the profession with some wonderful pictures and resources on the development of the profession over this century

International Confederation of Midwives (ICM)

The College of Midwives has always taken its relationship with ICM seriously and has utilised the Confederation's position statements and activities to the advantage of New Zealand midwives. From 1990 until 2002 when Sandy Grey took over the role of Asia Pacific regional representative from Karen, representation to three yearly ICM conferences and the mid-triennium regional conferences and Executive meetings has always been Karen and the National Chairperson/President of the College. Over these thirteen years the College has become increasingly anxious about ICM's direction and purpose. Along with several other member organisations such as the Dutch Midwives Association, the

Association of Radical Midwives (UK), and theMidwives Alliance of North America, the College has tried to address these issues with ICM from time to time. This has led to the College of Midwives always having had a somewhat tense but respectful relationship with ICM. The tension relates to the College's feminist and egalitarian partnership worldview versus the established and traditional bureaucratic ICM. At the first ICM attended by the College in Kobe, Japan in 1990, ICM attempted to expel the College from ICM because of its consumer membership. New Zealand argued that it was a philosophical and ethical stance to include women in its organisation. The congress accepted this position as it was obliged to under its constitution but expected New Zealand to further explain its position and present this to the next ICM congress in 1993 in Vancouver. This New Zealand did and proposed a position statement on midwifery being a partnership between women and midwives. Interestingly the position statement was adopted by the ICM membership but without the support of the American College of Nurse Midwives, the Royal College of Midwives and the Australian College of Midwives. However, the accompanying ICM constitutional changes we sought which would have made consumer membership more transparent within ICM were not accepted.

For New Zealand the line between education and colonisation of the world's midwives is often grey within the ICM activities. The Executive has always had strong British and colonial representation and a poor history of consultation and representation with other member countries, especially non-English speaking countries. Some of the responsibility for this rightly belongs to the member countries. However, it may also reflect ICM's lack of relevance to less well-resourced countries. ICM is still strongly influenced by nursing and medicine and it increasingly is taking on functions that more rightly belong to other organisations such as WHO, UNICEF and JPHEIGO. While accepting ICM has a legitimate role in influencing and working with world aid agencies it should not be at the expense of midwives and midwifery. New Zealand has always argued at Executive meetings that the ICM is the world's only specific international midwifery organisation and that midwifery should therefore be its primary focus. To not do this runs the risk of diluting the midwifery role and presence.

The National Committee has come close on several occasions to withdrawing its membership to ICM because of these difficulties. However, the College ultimately believes it has something to offer international midwifery and is loath to give away any ability to positively influence the development of global midwifery. Every time the College attends any international forum, including ICM, there is always huge interest from other midwifery organisations and countries in the New Zealand model of midwifery. New Zealand has been visited by Japanese, Norwegian, Canadian, Irish, Danish Australian and Dutch health officials and midwifery representatives who have been interested in understanding how New Zealand has achieved its maternity and midwifery service model. Some of these countries have used the New Zealand midwifery partnership model and the Bachelor of Midwifery education curricula to inform and develop their own practice models.

WABA, NZBA, BFHI

The New Zealand Breastfeeding Authority (NZBA) was formed in 1999 and as Julie Stufkins, NZBA coordinator reports, this was mainly due to the support of the New Zealand College of Midwives and the work of Karen Guilliland and Bronwen Pelvin

(Stufkins 2003). The College funded and organised the first meeting of all stakeholders with an interest in breastfeeding to meet in Christchurch and initiate the Baby Friendly Hospital Initiative (BFHI). To get this initiative going required the establishment of the New Zealand Breastfeeding Authority whose role was to monitor.

Conclusion

The primary role and responsibility of the College is to lead and promote appropriate and continued development of the profession to ensure midwifery provides the standard of care which women require if they are to have a full, safe and satisfying maternity experience. In order to meet the goals of a professional organisation the structure itself has to facilitate and enable professionalism to flourish. The College redefined professionalism to mean in partnership with women. Therefore the College's structures also needed to reflect partnership. Consumer members at regional and national level were involved in every aspect of the profession's development and in every activity of the College.

This chapter has described how the College developed and funded its organisational framework to support the needs of its membership to take on their new professional role and to facilitate midwives partnership with women.

The evolution of the College as described in this chapter was both conscious and strategic. It was also a staged evolution as the College consciously worked to lead midwives at a pace that allowed them to take ownership and pride in their progress without exhausting their resources or stretching society's understanding of the role of the midwife. It also required that processes developed in parallel. For example midwives had to have access to education and professional development while expanding their scope of practice. Midwives had to have funding mechanisms that would support their autonomous role while they learned what this role entailed. The priority given initially to developing the community-based independent midwifery services was essential to developing this model as an alternative to the traditional hospital maternity services women were striving to change. Once this model existed in the community hospital midwives were able to use it to argue for the development of similar services within the hospitals. Midwifery unashamedly took its lead from the socio-political context of the decades in which it has re-emerged as a profession. It recognised the ideologies of the time and reorganised and redefined them to suit the needs of pregnant and birthing women and their attendant midwives. For example, informed consent and patient's rights provided a platform from which to argue for a women-centred maternity service.

REFERENCES

National Midwives Section (1986). *Minutes of Annual General Meeting 9/4/86,* Unpublished.

National Midwives Section (1988b). *Minutes of National Midwives Section meeting 4/8/88,* Unpublished.

New Zealand College of Midwives. (1991a). *Annual Report, August.* Unpublished.

New Zealand College of Midwives. (1991b). *Minutes of Annual General Meeting,* Unpublished.

New Zealand College of Midwives (1992) *Minutes of Annual General Meeting*, Unpublished.

New Zealand College of Midwives (1993) *Minutes of Annual General Meeting,* Unpublished.

New Zealand College of Midwives. (1994). *Newsletter,* August/September. Unpublished.

New Zealand College of Midwives (1996) *Minutes of Annual General Meeting,* Unpublished.

New Zealand Nurses Association (1988). *Towards a corporate plan for NZNA*, Wellington: Author

Richards, J. (1992) *NZCOM Report of the National Committee meeting 15th February*, Unpublished.

Stufkins, J. (2003). Breastfeeding: are we making a difference? Editorial. *New Zealand College of Midwives Journal*, October, p.4.

Chapter
2

Towards self-determination: the separation of the midwifery and nursing professions in New Zealand

Sally Pairman

Introduction

Eleven years ago, midwives regained the legal right to practise without the supervision of doctors. This occurred through the 1990 Amendment to the Nurses Act 1977, and for many midwives and women it was the successful culmination of a long campaign for midwifery autonomy. It was also a significant step in midwifery's progress to self-determination.

Midwifery has now established its own tradition of autonomous practice with a clear and distinct place within the health system. Its relationships with nursing and medicine have been clarified as midwifery is defined as a specialty in its own right. Today midwifery stands as a strong profession with an identity and philosophy, and a determination to *'do professionalism differently'* by working in partnership with women (Tully, 1999).

This new form of professionalism seeks equal status and power sharing between the midwife and the woman and rejects the traditional notion of the midwife as the 'expert'. Instead, the woman and the midwife are both seen as experts, both making contributions that are essential to a successful relationship and to positive outcomes for the woman and her baby. This partnership relationship involves equity, reciprocity, negotiation and accountability and is based on trust and knowledge of each other gained over time through continuity of care (Guilliland and Pairman, 1995). Partnership, as a form of professional practice, exists not only in the individual midwife-woman relationship but also at other levels of the profession.

Partnership underpins the organisational structure of the New Zealand College of Midwives (NZCOM) and its policy and decision-making mechanisms and processes. It exists at the political level between the College and maternity consumer groups, and underpins all midwifery curricula and teaching/learning processes in midwifery education.

New Zealand midwifery claims that its professional status rests with women, and that midwifery has a moral obligation to provide the kind of midwifery care that women want. When articulating midwifery as a partnership of equal status, New Zealand midwives have redefined the traditional view of professionalism. They say:

> Instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that women can control childbirth. Midwifery must maintain its women-centered philosophy to ensure that its control of midwifery never leads to control of childbirth.
>
> *(Guilliland and Pairman, 1995: 49)*

This chapter explores the development of midwifery as a profession in New Zealand. It examines midwifery's relationship with nursing in order to explore the reasons that midwifery chose to separate itself from nursing, aligning instead with women. It explores how midwifery clarified its identity and developed strategies to bring about midwifery autonomy, separate from nursing, and to take responsibility for its own destiny.

Midwifery then and now

Over the years since 1904 and up to 1990, the effect of midwifery regulation was to cement the erosion of midwifery autonomy and reduce its scope of practice. These changes occurred in a context of increasing hospitalisation, medicalisation of childbirth, and medical dominance in the health system overall. Legislation supported medicine's preference for nursing assistance at birth and the puerperium, rather than full midwifery provision of maternity services. Extensive discussion of this legislation, its social and political context and its impact on midwifery, medicine and nursing can be found in a variety of texts (Donley, 1986; Mein-Smith, 1986; Kedgley, 1996; Papps and Olssen, 1997).

The 1990 Amendment to the Nurses Act 1977 which reinstated midwifery autonomy was also the result of broad social change reflecting a context in which women's issues were of concern, medical dominance was being challenged and cost-effective health services were being sought. The opportunities provided by this legislation have enabled the midwifery profession to establish itself for the first time as a truly autonomous profession.

In 2001 midwifery again provides the core maternity service in New Zealand, as it did in the early part of the twentieth century. Women are again experiencing continuity of care with midwives, with 71% of women choosing a midwife as their Lead Maternity Carer (LMC) for labour and birth in 2000 (Health Funding Authority, 2000).

Midwives and nurses

Midwifery: a speciality of nursing or a speciality in its own right?

At the heart of disagreements between midwifery and nursing is the different understanding each group has of midwifery as a speciality in its own right with its own sphere of practice or as a speciality area of nursing practice. This philosophical position is reflected in the different views of nursing and midwifery when it comes to the educational preparation of midwives. Thus the tension between nursing and midwifery has invariably centred around education.

It is hard to know how midwives felt about restrictions to their scope of practice from 1904 to 1971. Historical accounts do not address the issues from the perspective of midwives as a group. Midwifery did not have a separate voice within the Health Department but was represented by nurses such as Grace Neill, Mary Lambie and Hester Maclean, who also held midwifery registration. Certainly, they were strong advocates for midwifery, as were doctors Henry Jellett, Tom Paget and Truby King (Mein-Smith, 1986). Their support for midwifery was rooted in their belief that midwifery served women better than medicine in normal childbirth. Whilst midwifery training, midwifery registration and midwifery autonomy were supported, there did not appear to be any concern about separating midwifery and nursing. While a direct-entry route to midwifery education remained until 1957, there was support from 1925 onward for midwifery to be seen as a postgraduate nursing course. This was intended to raise its status through the necessarily longer training. Midwives in the early part of the century were concerned about competition with doctors rather than about the integration of midwifery within nursing.

However, by 1925 midwives were becoming concerned about the influence of nursing over their profession. The 1925 Nurses and Midwives Registration Act amalgamated the regulation of the two professions and effectively gave control over midwifery education and practice to nursing. A shortage of midwives in the 1930s and 1940s led to suggestions that midwifery training should be discontinued and that doctors and maternity nurses should provide all maternity services. Maternity nurses did not require the same level of clinical experience as midwives and this would free up more 'clinical material' (women) for medical student experience (Donley, 1986). Later recommendations suggested combining maternity into the general nurse training, so that all nurses would have knowledge of obstetrics and some could continue on to midwifery without undertaking additional maternity nurse training. Mary Lambie successfully fought this plan, claiming that it provided superficial training, and the plan was shelved until her retirement (Donley, 1986).

The changes were finally made in 1957 despite much opposition from midwives who claimed that nurses brought their pathological outlook inappropriately into maternity work and that women suffered from care by nurses who were not really interested in maternity care (Donley, 1986). Nursing curricula were changed to include maternity nursing, leading to a double certificate of registered nurse and registered maternity nurse (later known as Registered General and Obstetric Nurse). These nurses were then eligible for the shortened six-month midwifery programme. The new obstetric component

of the general nurse training was taught in the maternity annexes of public hospitals and midwifery training continued in the St Helen's hospitals. The number of midwifery places available for maternity nurses were restricted in favour of nurses and gradually the separate maternity-nursing programme (the direct-entry route to midwifery) was phased out and nursing registration became a prerequisite to midwifery. The curriculum remained in place until 1979 when midwifery training was transferred to the tertiary education sector (Donley, 1986).

The Carpenter Report 1971

The Carpenter Report culminated in a shift from hospital-based apprentice-style training to a polytechnic-based, student-focused education system (Papps, 1997). The new nursing curriculum prepared the 'comprehensive nurse' who was able to provide care in a variety of health-care settings. Carpenter saw midwifery as post-basic nursing and argued that this course should be improved by shifting it into the tertiary system and the more élite theoretical education system (Donley, 1986). The practical 'hands on' St Helen's midwifery training that had prepared midwives to manage normal birth independently came to an end in 1979 with the adoption of the Carpenter Report (Donley, 1986).

The role of the New Zealand Nurses Association (NZNA)

The NZNA was established in 1909 as the New Zealand Trained Nurses Association and was the only professional voice for nurses until the 1990s. Because of the small numbers of nurses and midwives in New Zealand and communication difficulties created by the country's geography, midwives were encouraged to join the association. To maintain some focus on their specific interests, midwives and maternity nurses set up the Obstetrical Group within the NZNA in 1935. This was upgraded in 1969 to the Midwives and Obstetrical Nurses Special Interest Section (Midwives Section) to enable them to join the International Confederation of Midwives (Donley, 1986).

Despite membership of the same professional organisation, it soon became clear that midwifery's interests were not the same as those of nursing and were not being served by the professional organisation. The NZNA, against the wishes of midwives, strongly supported the placement of midwifery education in the tertiary sector as a post-basic nursing specialty. The integration of midwifery training into the Advanced Diploma of Nursing (ADN) programme from 1978 onward was incongruent with midwifery's need for in-depth specialist midwifery education, and this shortened programme was never able to meet the needs of midwives or women. Providing two programmes within the one academic year (ADN and midwifery registration) allowed for only 10 to 12 weeks of midwifery clinical experience and limited theory. Graduates required significant support for long periods of time as they made the transition to becoming competent registered midwives (NZNA, 1987). Potential students chose to travel overseas for midwifery training, and from 1980 the number of midwives registering from the ADN/Midwifery programmes decreased dramatically from an average of 160 per year in the St Helen's programmes of

the 1970s to an average of 25 per year in the 1980s (Donley, 1986). The shortage of midwives in New Zealand today can be attributed in part to this decline in midwifery training in the 1980s (Guilliland, 2001).

Conflicts with nursing

Having failed to stop the closure of the St Helen's programmes, the Midwives Section made repeated submissions to the NZNA for support to establish midwifery as a one-year separate programme instead of the ADN model (Donley, 1986). However, the Nurses Association policy was opposed to a separate course and the Association held to its position that a midwife was a nurse first and that midwifery education was a post-basic nursing course (NZNA, 1981). Successive remits presented at annual meetings requesting separate midwifery education from the ADN were actually passed in 1980, 1982, 1984 and 1985. Despite this, the NZNA continued to produce policy supporting the programme (NZNA, 1984). Midwives Section members were told by the then Executive Director that with only 600 midwives and more than 20 000 nurse members, midwives could not expect to sway the opinion of the nursing profession (Donley, 1987). Disagreements with the nursing profession about midwifery education and concern about the divergent needs of the two groups and lack of 'voice' for midwifery were certainly an impetus for midwives to begin to think seriously about separating from the NZNA. The other main impetus began with the 1983 Amendment to the Nurses Act.

1983 Amendment to the Nurses Act 1977

From the late 1970s, home birth came under medical and nursing scrutiny. Hospital midwives by now were strongly entrenched in the medical model of childbirth that was reflected in their training and in their everyday practice. Antagonism between hospital midwives and domiciliary midwives was rife. This was exemplified by the 1981 Policy Statement on Maternal and Infant Health that proposed strict criteria for the preparation and practice of domiciliary midwives (NZNA, 1981).

An unplanned home birth and water birth in Auckland in 1982 which resulted in a post-natal transfer to hospital provided the impetus for the Nurses Amendment Bill that was introduced in 1983. This Bill was targeted mostly at domiciliary midwives, although it also had implications for hospital-based midwifery practice. Midwives were no longer required to attend women in childbirth, allowing nurses and enrolled nurses, under the supervision of midwives, to carry out this care. Only comprehensive nurses were to have access to midwifery training. All domiciliary midwives had to be nurse-midwives and the Medical Officer of Health could suspend a midwife for 'suspicion' of unhygienic practices (Donley, 1986). The Midwives Section was incensed by the downgrading of midwifery and prepared a submission to the Select Committee on the Bill. However, the National Executive of NZNA would not allow it to be submitted because it was at variance with the Association's policy. For the first time, many midwives understood their lack of 'voice' within the larger nursing organisation.

It was consumers who publicly raised most of the problems with the Bill and succeeded in having amendments made. A group of home-birth women formed 'Save the Midwives Society' and quickly developed into a strong national consumer group. They succeeded in having small changes made to the subsequent Act (Donley, 1986).

The 1983 Nurses Amendment Act had some unexpected consequences. It united hospital and domiciliary midwives with a common cause for the survival of the midwifery profession and it politicised the Midwives Section members. They began to think about a separate organisation to represent their interests. Midwives increasingly recognised that they shared many concerns with the maternity consumer groups. The profession took the first steps towards aligning itself with women rather than with nursing.

Demanding a voice

By 1985, lobbying by the Midwives Section had achieved not only a change in NZNA policy to support a separate midwifery programme, but also the adoption of the World Health Organisation definition of a midwife as *'a person who ...'* instead of its previous policy that a midwife was *'a nurse who ...'*. However, the National Executive did not act on this policy, continuing instead to block midwifery's access to decision makers in the Departments of Health and Education (Donley, 1987).

In 1986 the regional Midwives Sections joined together in a national conference in Christchurch and for the first time the possibility that midwives might leave the Nurses Association and form a separate professional organisation for midwifery was debated nationally. The NZNA was very concerned about this possibility and sent two of its executive members to lobby midwives and persuade them not to leave (Donley, 1987). In an effort to meet some of midwifery's concerns, the Nurses Association established a committee in 1987 to revise and update its 1981 policy on Maternal and Infant Health. Three of the five-member committee were representatives of the Midwives Section. The extensive consultation process that followed included 140 women's groups as well as midwives throughout New Zealand in midwifery's first attempt to involve women in policy development (Bickley, 1989). The resultant *Midwifery Policy Statement* clearly outlined a future for midwifery based on autonomy and continuity of care, and a midwifery philosophy of practice. This policy called for discontinuation of the ADN/Midwifery programmes and supported direct-entry midwifery education as one route to midwifery registration (NZNA, 1989). It became NZNA policy in 1989 but by then it was too late to stop midwifery separating from nursing.

A further impetus for separation from nursing came in 1987 when midwives discovered that executive members of the NZNA were planning to meet with officials from the Health and Education Departments to discuss the future of midwifery education. The Midwives Section was not invited to participate in this meeting. Midwives insisted on representation. Various options for midwifery education were discussed but nurses refused to consider direct entry with the Chief Nurse stating that this would occur *'over my dead body'*. The two midwife representatives at the meeting (Sally Pairman and Karen Guilliland)

also found themselves in conflict with the Director of the NZNA, having to remind her that separate midwifery education was now actually NZNA policy, and that she was therefore obliged to support that position in the discussions. The outcome of the initial meeting was an agreement that separate one-year midwifery programmes would be established in three locations and evaluated against the remaining two ADN/Midwifery programmes. Sally Pairman and Karen Guilliland were nominated as the Midwives Section representatives to the working party that would oversee this change.

The Working Party on Midwifery, Bridging and Related Courses was established in 1987 to make recommendations on the phasing in of one-year separate midwifery programmes. This involved reallocation of funding to phase out bridging programmes and establish the one-year separate midwifery programmes and short courses.

Separate one-year midwifery programmes

In 1989 AIT, Wellington and Otago/Southland Polytechnics commenced one-year midwifery programmes. Waikato and Christchurch were required to continue offering the ADN/Midwifery option to provide control groups for the evaluation process. This evaluation was to run from 1989 to 1992 when a decision would be made about the future direction of midwifery education. In the event, however, other contextual issues overtook the evaluation. The 1990 Nurses Amendment Act reinstated midwives as autonomous professionals and put discussions about direct-entry midwifery back on the table. Students refused to enrol in the ADN/Midwifery programme, insisting instead on access to the one-year midwifery programme. The market-driven polytechnics responded by closing the remaining ADN courses at Waikato and Christchurch in 1991, commencing separate programmes in 1992. The Department of Education review was never completed, as there was no longer a market for the ADN/Midwifery option. Politics had overridden policy.

Separating midwifery from nursing

Working with women

The years 1983 to 1990 saw an awakening understanding amongst midwives that their practice could be expanded. The majority of midwives at this time practised in hospitals as part of a fragmented maternity system controlled by medicine. The only midwives practising with a sense of autonomy and understanding of continuity of care were a very small number of domiciliary midwives in the home-birth setting (Donley, 1986). However, there were some consumers who were aware of what midwifery could offer and they were determined to bring about change. The consumer group, 'Save the Midwives', lobbied for an autonomous midwife who could provide an alternative to the dominant medical model of maternity care (Strid, 1987).

A sub-group of Save the Midwives formed the 'Direct Entry Midwifery Taskforce'. Its main objective was to achieve direct-entry midwifery. These women believed the system of midwifery training following nursing registration

was both inappropriate and a waste of resources. As a profession in its own right, midwifery needed its own education programmes to produce motivated, competent and autonomous midwives (Strid, 1988). So while midwives fought for separate one-year midwifery programmes for nurses to train as midwives, women challenged midwives to think beyond this to direct-entry midwifery.

By 1988 Karen Guilliland was leading the Midwives Section as the National Chairperson and she understood clearly, as did the various consumer groups, the potential strength of their combined political activity. Women's need to regain control over childbirth and midwives' desire to regain independence in their practice were complementary. As a first step to achieving direct-entry midwifery, the groups agreed to focus on achieving midwifery autonomy. The campaign involved repeated personal submissions by women and midwives to every politician in New Zealand over the next two years as well as formal submissions to the then Minister of Health, Helen Clark. Helen Clark introduced the Nurses Amendment Bill to Parliament where both sides of the House supported it. This political campaign also took place in a context where women's issues were high on the political agenda and the Cartwright Report on the National Women's Inquiry had raised issues to do with abuse of professional power and the rights of the consumer. Thus midwifery's argument for a non-interventionist and client-focused approach to maternity services was compatible with the Government's health funding policies (Tully, 1999). This political collaboration of women and midwives in the years from 1983 was successful in re-establishing midwifery autonomy, but before that it also set the scene for a new professional organisation for midwives.

Establishing the New Zealand College of Midwives

The experience of collaboration with women in the political activity leading to the 1990 Amendment enabled midwives to recognise the interdependent nature of their relationship with women. Midwives understood that active involvement of consumers in the midwifery profession strengthened midwifery. Midwifery had been able to achieve much more through working with women than it ever had working with nurses. Unlike the nursing profession, women understood and shared midwifery's concerns and vision as their own, and were willing to help achieve these shared goals. So by the time Joan Donley challenged midwives at the 1988 National Midwives Conference to form their own professional organisation and disband the Midwives Sections of NZNA, midwives were ready to do it. They were also ready to do it in partnership with women.

Fifty midwives and women joined immediately by paying $50 to the as yet unstructured organisation. When the College formally opened in 1989 it was based on a constitution that established midwives and consumers as equal members at every level of the organisation (Guilliland, 1989). 'Women's participation in the midwifery profession has given midwives a public, legal and socially sanctioned mandate for practice' (Guilliland and Pairman, 1995: 19). The active involvement of women in the policy formation and processes of the NZCOM helps to ensure that midwives uphold this mandate and work to meet the needs and wishes of women in the provision of midwifery care.

This experience of midwife/woman partnership at a political and organisational level has enabled New Zealand midwives to recognise that their daily practice with women is also one of partnership. This understanding of partnership is expressed in midwifery's Philosophy, Standards for Practice and Code of Ethics (NZCOM, 1993). The New Zealand College of Midwives provided a united professional voice to address midwifery education issues. It was also the forum to develop and implement strategies that would cement midwifery autonomy in the years following the 1990 Amendment.

1990 Amendment to the Nurses Act 1977

Under the amendment only a doctor *or* a midwife could supervise the care of a pregnant woman. Midwives and doctors once again had equal status in provision of childbirth services. For midwifery autonomy to be a reality, amendments had to be made to a variety of different Acts and Regulations to support the changes to the Nurses Act (Department of Health, 1990). Under these changes, midwives gained the right to authorise laboratory tests, to admit and care for women in hospital, to prescribe medication, to make direct referrals to obstetricians and other specialists, and to be paid from the Maternity Benefit Schedule on the same basis as doctors. The legislation also gave a place, as of right, to a midwife nominated by the NZCOM on the Nursing Council of New Zealand, thus recognising the College rather than the NZNA as the professional body for midwives.

The 1990 Nurses Amendment Act dramatically altered relations between midwifery and medicine and midwifery and nursing. The legal autonomy of midwives established midwives and doctors as equal players in provision of maternity care. With the same jurisdiction over provision of publicly funded maternity services, midwives and doctors were in competition with each other for clients (Tully, 1999). The last decade has seen this competition played out against a background of changing government ideology and policy, which has brought major changes to the wider health system, and restructuring of the maternity system and payment mechanisms. The Maternity Benefit Tribunal of 1993, the Section 51 Advice Notices of 1996 and 1998, and the Referral Guidelines of 1996 all upheld the rights of midwives to autonomous practice and equal status with general practitioners in provision of maternity care.

The significance of funding

This chapter was not intended to explain the maternity funding system in detail and the interested reader is referred to a number of theses that can provide this information and analysis (for example, Abel, 1997; Guilliland, 1998; Pairman, 1998; Tully, 1999). However, a discussion of how midwifery positioned itself in the market place against competition from both medicine and nursing follows.

Midwifery as a primary health service gained access in 1990 to primary health funding through the Maternity Benefit Schedule, or Section 51 as it is commonly known. Up to this point the majority of midwives were employed in hospitals. The Nurses Association (which later became the Nurses Organisation) was the bargaining agent, negotiating wages and conditions for all employed midwives.

The NZCOM, as the bargaining agent for self-employed midwives, took advantage of the health reforms and their economic restructuring programmes to consolidate midwifery's position as a primary health service and competitor with medicine. Once pay equity with medicine had been achieved, on the basis of the argument that both midwifery and medicine provided a normal childbirth service, it was essential to hold onto this. Since the passing of the 1938 Social Security Act, doctors have been able to claim a fee-for-service from central government for maternity care. When midwives were granted the right to access the maternity benefit payment schedule in 1990, at the same rate as doctors, it effectively enabled them to be self-employed. Although the fees for each service were set, midwives could be paid directly by government and were no longer reliant on hospital employment.

Self-employment brought with it independence from nursing and medicine, through their control of hospitals, and gave midwives a much stronger position from which to develop their practice and profession. The NZCOM understood that continued self-employment was a survival mechanism for midwifery and has made retaining this ability a priority over the last 11 years. The bottom line of all negotiations over funding and the redesigning of the maternity system has been to retain a single-payment mechanism and pay equity with doctors.

However, the NZNO was slow to understand the importance of self-employment for midwives. As a union movement, it supported collective bargaining and was philosophically opposed to self-employment and fee-for-service payment models. The NZNO led resistance by hospital midwives to the self-employed midwives and contributed to the antagonism between these two groups in the early 1990s. Eventually Steph Breen, founder of the Nurses Union and the then joint CEO of the NZNO, was able to convince her organisation of the significance of this funding mechanism for a workforce in which women were predominant. With support from the College, the NZNO was able to use the payment achievements of self-employed midwives to argue for pay equity for hospital-employed midwives. The resultant variance clauses to the Nurses Award negotiated for hospital midwives gave them significant pay increases – all based on parity with self-employed midwives.

Funding and practice opportunities similar to those given to midwifery with legal autonomy have so far been denied to nurses (Tully, 1999). If midwifery had remained as an advanced career option for nurses through continuation of the post-basic training, midwifery autonomy could have been of advantage to nursing (Tully, 1999). 'By facilitating the introduction of direct-entry midwifery education the Act played a critical role in enabling midwifery to consolidate an independent professional status' (Tully, 1999: 82).

Towards direct-entry midwifery education

Midwifery separated itself from nursing through the establishment, in 1989, of its own professional organisation and the development of policy that articulated midwifery as an autonomous profession. At the same time, the Direct Entry Midwifery Taskforce, a group of women and midwives, was working towards a new structure for midwifery education. In conjunction with Carrington Polytechnic and with the endorsement of the NZCOM, the Taskforce released

a discussion document and draft direct-entry midwifery curriculum to a large number of interested parties and politicians (Save the Midwives Direct Entry Midwifery Taskforce, 1990).

Carrington Polytechnic submitted its curriculum to the Nursing Council in 1990 and this was turned down with the Council citing legislative barriers as well as philosophical disagreement with direct-entry midwifery as its reasons. This stance by the Nursing Council concerned Helen Clark who considered that the Council was empowered to administer the Nurses Act, not to have a philosophical position on the direction of midwifery education. At the first NZCOM National Conference in Dunedin in August 1990, Helen Clark told midwives that she intended to remove legislative barriers to direct-entry midwifery. If the Council still showed no tolerance for such a programme, it would 'open up to question whether the Nursing Council is the appropriate body to govern midwifery' (Clark, 1990: 9–10). During the second reading of the Nurses Amendment Bill, Helen Clark introduced legislative changes that would enable the introduction of direct-entry midwifery.

Section 39 of the 1990 Amendment paved the way for direct-entry midwifery and two three-year programmes commenced in 1992 under this experimental clause. These were a diploma programme at AIT and a Bachelor of Midwifery degree at Otago Polytechnic. Another three programmes commenced in 1996 after the evaluation had been completed. There are currently five direct-entry programmes, all of which award a Bachelor's degree.

Direct-entry midwifery education at last gave the profession the opportunity to prepare midwives for their full scope of practice. With the removal of the pre-requisite nursing registration, midwifery had the opportunity to consolidate its professional identity independent from nursing. Establishing midwifery as a pre-registration course alongside nursing clearly identified it as a different career option. The new programmes made it possible to provide the in-depth focus on midwifery knowledge and practice necessary to produce midwives who were 'specialists' in normal childbirth, and to give them the skills to practise independently of doctors. Midwifery had always supported apprenticeship-type midwifery education and these new programmes combined the best of theoretical educational models with apprenticeship models to facilitate development of evidence-based knowledge from a strong practice base. In creating midwifery academics, direct-entry midwifery also set the scene for definition and construction of midwifery 'discourse' (Tully, 1999). Midwifery has begun to articulate and record its knowledge base, to carry out original research and to identify what it is that midwifery offers women that distinguishes it from other professional groups involved in maternity care.

Direct-entry midwifery also provided a framework into which nurses could be incorporated on midwifery's terms. With the rapidly changing practice opportunities for midwives and increasing expectation of independent practice, the one-year separate midwifery programmes could no longer prepare nurses who would have the necessary knowledge and skills for this new practice context. Nurses now complete the Bachelor of Midwifery degree, with some credits – in recognition of skills and knowledge shared between midwifery and nursing. By putting direct-entry and nursing midwifery students together

in one Bachelor-level programme, midwifery has cemented its position as a separate profession to nursing, thus removing any opportunities to re-establish midwifery as a post-basic course for nurses. The message is clear. Entry to the nursing or midwifery professions is through separate bachelor-level programmes. Nurses wishing to change their career and take up midwifery are required to complete another bachelor's degree programme in this different discipline. Likewise, direct-entry midwives who wish to move into nursing are required to undertake a bachelor's programme for entry into that profession.

Midwifery and nursing today

The last few years have seen the development of more collegial relationships between midwifery and nursing. Nursing appears to have understood that midwifery autonomy is not about rejection of nursing, but rather about self-determination for midwifery. The separation of the two professions has continued and this is most clearly seen in the policy and activity of the Nursing Council of New Zealand.

Although the Nursing Council remains the regulatory body for midwifery at present, it has stated its belief that nursing and midwifery are two separate professions (Nursing Council of New Zealand, 2000). There are now more midwife members on the Council than was previously the case. The Council has worked in partnership with the College and used separate processes to develop and consult on policy, producing, for example, different processes for the ongoing competency assessment of nurses and midwives.

The separation of the two professions has also been of advantage to nursing, as it has been able to use midwifery's example to lend weight to its arguments for such developments as nurse prescribing. Instead of the 'and midwifery' that was tacked on to nursing from the early 1990s, there is now a sense of real understanding of the differences between the professions and a will to implement policy that addresses each profession's specific needs.

In 2001 new legislation is planned that will provide a single regulatory framework for all health professional groups, including nursing, midwifery and medicine. Under the proposed Health Professional Competency Assurance Bill, midwifery will at last have its own Midwifery Council and the opportunity to regulate its own profession. Midwifery will finally be completely in charge of its own destiny.

Conclusion

This chapter has explored the development of midwifery as a profession in its own right. While its origin was that of an autonomous occupation, midwifery became more and more subsumed by nursing as a result of medicine's determination to control maternity services in New Zealand. Eventually midwifery lost its legal autonomy and became a post-basic specialty of nursing. With support from maternity consumer activists who believed in midwifery and what it could offer women, midwives began to claim back their separate professional identity. This has been painful at times. Nursing as a profession has struggled to understand midwifery's concerns and has resisted the changes.

However, midwifery's alliance with women gave the profession strength and it pushed on to achieve its vision. Separating from nursing was a necessary part of achieving that vision, as midwifery autonomy was never going to be possible if it remained part of the nursing profession.

Today the two professions are distinctly different. Each has its own vision for the future and its own strategies. The two professions now have a positive collegial relationship and both are in a stronger position to take advantage of whatever opportunities the future may hold.

References

Abel, S. 1997. Midwifery and maternity services in transition: an examination of change following the Nurses Amendment Act 1990. Unpublished Doctoral thesis. University of Auckland, Auckland.

Bickley, J. 1989. 'Attempting to involve consumers in midwifery policy development', *New Zealand College of Midwives Journal*, 1: 11–13.

Clark, H. 1990. 'Opening address'. *Proceedings of the New Zealand College of Midwives National Conference – Women in Partnership*. Dunedin, 17–20 August.

Department of Health. 1990. *Nurses Amendment Act 1990. Information for providers*. Department of Health, Wellington, October.

Donley, J. 1986. *Save the Midwife*. New Women's Press, Auckland.

Donley, J. 1987. Has the NZNA served the interests of midwives? Unpublished paper.

Guilliland, K. 1989. 'Maintaining the links – a history of the formation of the NZCOM', *New Zealand College of Midwives Journal*, September: 14–15.

Guilliland, K, 1998. A demographic profile of self-employed (independent) midwives in New Zealand. Unpublished Masters thesis. Victoria University of Wellington, Wellington.

Guilliland, K. 2001. Interview. Radio New Zealand, March.

Guilliland, K. and Pairman, S. 1995. *The Midwifery Partnership: a model for practice*. Monograph series 95/1. Department of Nursing and Midwifery, Victoria University of Wellington, Wellington.

Health Funding Authority. 2000. *Maternity Services: A reference document*. Health Funding Authority, Hamilton.

Kedgley, S. 1996. *Mum's the word. The untold story of motherhood in New Zealand*. Random House, Auckland.

Mein-Smith, P. 1986. *Maternity in Dispute. New Zealand 1920–1939*. Historical Publications Branch Department of Internal Affairs, Wellington.

New Zealand College of Midwives. 1993. *Midwives Handbook for Practice*. New Zealand College of Midwives, Dunedin.

New Zealand Nurses Association. 1981. *Policy Statement on Maternal and Infant Nursing*. NZNA, Wellington.

New Zealand Nurses Association. 1984. *Nursing Education in New Zealand: A Review and Statement of Policy*. May, NZNA, Wellington.

New Zealand Nurses Association. 1987. *An Evaluation of the Advanced Diploma in Nursing Courses. NZNZ comments on the report*. NZNA, Wellington.

New Zealand Nurses Association. 1989. *Midwifery Policy Statement*. NZNA, Wellington.

Nursing Council of New Zealand. 2000. *Strategic Plan 1 April 2000 to 31 March 2003*. Nursing Council of New Zealand, Wellington.

NZCOM *see* New Zealand College of Midwives.

NZNZ *see* New Zealand Nurses Association.

Pairman, S. 1998. The Midwifery Partnership: An Exploration of the Midwife/Woman Relationship. Unpublished Masters thesis. Victoria University of Wellington, Wellington.

Papps, E. 1997. Knowledge, power and nursing education in New Zealand: a critical analysis of the construction of the nursing identity. Unpublished Doctoral thesis, University of Otago, Dunedin.

Papps, E. and Olssen, M. 1997. *Doctoring childbirth and regulating midwifery in New Zealand. A Foucauldian perspective.* Dunmore Press, Palmerston North.

Save the Midwives Direct Entry Midwifery Taskforce. 1990. 'Direct entry to midwifery', *Save the Midwives Newsletter,* 23 May: 12–20.

Strid, J. 1987. 'Maternity in revolt', *Broadsheet,* no. 153: 14–17.

Strid, J. 1988. 'Midwifery education for the future: a joint decision', *Save the Midwives Newsletter,* no. 15, May: 1.

Tully, E. 1999. Doing professionalism 'differently': negotiating midwifery autonomy in Aotearoa/New Zealand. Unpublished Doctoral thesis. University of Canterbury, Christchurch.

Midwifery Standards Review: a strategy for credentialling

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Introduction

This paper outlines the New Zealand College of Midwives' (NZCOM) perspective on credentialling and demonstrates how existing mechanisms can be utilised as a credentialling strategy for midwives. The paper was written in November 2000 and updated in September 2001 in response to the College's concerns that Ministry of Health work with doctors over credentialling could be inappropriately applied to other health professional groups, including midwives.

Background to credentialling

From 1999 the Ministry of Health has worked with medical groups to develop a national credentialling framework for senior medical officers employed within District Health Boards (Ministry of Health, 2001). The purpose of credentialling is *"to protect patients by carefully defining the clinical responsibilities of practitioners. In doing so it also protects the hospital and District Health Board (DHB), which are required to ensure that appropriate systems are in place to manage service quality"* (Ministry of Health, 2001, p.1). The definition of credentialling in the New Zealand context is:

> *A process used to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment* (Ministry of Health, 2001, p.2).

The Ministry of Health (2001) further states that the funding agency is considered the 'employer' where practitioners are self-employed and publicly funded. The notion that credentialling could become part of access agreements to facilities is implicit in the document (Ministry of Health, 2001).

A recent Commerce Commission opinion reinforces the College's concerns that facilities have the potential to use their dominant position to unduly restrict self-employed practitioners from accessing their facility (Commerce commission letter to NZCOM 5/9/01). Facilities can (and some do) restrict access by requiring inappropriate conditions relating to training and competency which are related to their service and organisational needs rather than enhancing women-centered primary care. The effects of giving secondary care acute services control over primary practise is to "hospitalise" community maternity care.

Credentialling is about defining and monitoring the competence of a practitioner within a given scope of practice. It makes a distinction between the scope of practice defined by the professional body responsible for registration and the scope of practice defined by an organisation, which is likely to be narrower and more specific (Ministry of Health, 2001). Decisions about credentialling status are seen to belong to the organisation and are not necessarily transportable (Ministry of Health, 2001).

> *It is the role of the profession and the registration authority to determine scope of practice and competency of practitioners, not the employer.*

While in the first instance the credentialling framework has been developed for senior medical officers employed in hospitals by District Health Boards, the Ministry of Health is clear that it expects the development of credentialling processes for all health professional groups. The Ministry of Health states that the 'four-step' credentialling process is generic but that the process of credentialling may differ between professions (Credentialling Workshop Notes, 2001; Ministry of Health, 2001).

The 'four-step' credentialling process commences with initial credentialling on appointment and continues with ongoing credentialling or recredentialling for the term of the appointment. The two stages of initial credentialling and ongoing credentialling each have two steps. Step one involves verification of training, qualifications, experience and registration status and is the responsibility of the registration authority. Steps two to four are seen to be the responsibility of the organisation (employer). Step two is the determination of the scope of practice within the organisation. Step three is the ongoing collection of data for monitoring practice and recredentialling. Step four is the review and redefinition of practitioner scope of practice (Ministry of Health, 2001).

Issues for the midwifery profession

The New Zealand College of Midwives (NZCOM) is concerned that the credentialling process developed between the Ministry of Health and senior medical officers may, in the future, be applied to both employed and self-employed midwives by hospitals and District Health Boards. The credentialling framework developed by the Ministry of Health (2001) comes out of a 'managed care' ideology that is based on a reductionist or task approach and an outmoded economic model. Further, it focuses primarily on secondary care and organisational needs. While it purports to reduce risk to hospitals and District Health Boards, the College argues that it does the opposite. By judging the clinical competence of their staff, (a role currently reserved for the registration authority), employers may increase their risk if employed practitioners then go on to make an error. The College considers that credentialling in its current form would be entirely inappropriate for midwifery.

Midwifery is, in itself, a specialised and defined scope of practice for which midwives are educationally prepared and registered. Midwifery situates itself in primary health care. All midwives, no matter where they are employed, are educationally prepared to work in the full scope of midwifery practice. The College does not support any mechanism that has the potential to limit or redefine the scope of practice of midwives; particularly those who are employed by hospitals that offer secondary and tertiary maternity care services. It is the role of the profession and the registration authority to determine scope of practice and competency of practitioners, not the employer. The College provides other mechanisms, already in place, that can ensure at least the same level of protection to women and babies within the maternity service as that suggested by the proposed credentialling framework discussed above.

The last twelve years have expressly developed the midwife to her full role in order to provide women with continuity of care throughout their total maternity experience.

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This scope of practice cannot be redefined once again into tasks and altered by employers according to their organisational needs rather than the needs of women. On this basis the 'four-step' credentialling framework developed for doctors cannot be used for midwives. However steps one and three are an essential part of an employer's responsibilities. The NZCOM framework therefore incorporates certain aspects of the Ministry of Health doctor model but clarifies mechanisms that may be used by employers for the ongoing monitoring and support of midwives in their professional development and competency assessment. This alternative NZCOM credentialling framework is set out at the end of this paper.

Current mechanisms for midwifery competence and professional development

The NZCOM, in conjunction with a number of maternity hospitals throughout New Zealand, has already developed and implemented a cohesive process for ensuring that midwives remain competent in their practice. This process, known as "Midwifery Standards Review", also enables midwives to also meet the Nursing Council of New Zealand requirements for competency-based practising certificates.

The mechanisms that midwives and employers already have in place to maintain competency of midwifery staff are outlined below. The College suggests that this framework provides a mechanism for midwifery credentialling for other employers who may not yet be aware of the work done by the midwifery profession.

New Zealand College of Midwives

The New Zealand College of Midwives is the professional body for midwives in New Zealand. It currently represents 80% of the practising midwifery workforce. It members are both employed and self-employed midwives. The College encourages consumer involvement and makes places on all its national and regional committees for consumer membership. There are ten autonomous regional committees and five sub-committees in the smaller provincial centres. It is these committees together with consumers and Maori, who make up the National Committee of the NZCOM. The National Committee sets the policy and direction for the midwifery profession through consultation and consensus within its membership.

NZCOM Midwifery Standards Review Process

Each region of the NZCOM has a Midwifery Standards Review Committee that operates as part of a nationally agreed Midwifery Standards Review Process. The purpose of the Midwifery Standards review process is to assist midwives with their ongoing professional development by engaging in critical reflection of each midwife's work in the previous year with midwifery peers and consumers of midwifery services.

By participating in a Midwifery Standards Review, the midwife is involved in a supportive and educative process that gives her the opportunity to reflect on her practice in relation to the "Standards of Practice" as defined by the New Zealand College of Midwives (Inc) Midwives Handbook (NZCOM, 1993).

The Midwifery Standards Review team

- annually reviews the practice of member midwives;
- acts in partnership with consumers of midwifery services to ensure the accountability of midwifery practices;
- provides a supportive environment in which to reflect on and review a midwife's practice;
- provides a special review when requested by a midwife in any case of difficulty, unexpected outcome or special interest;
- reports identified themes and issues from midwifery practice to the region of the College and/or the National Committee.

The New Zealand College of Midwives Midwifery Standards Review committee consists of two midwives elected by their respective NZCOM region and two consumer representatives elected by their consumer organisation and/or by the NZCOM region.

Nursing Council of New Zealand Competence-based Practising Certificates

The Nursing Council of New Zealand is at present the regulatory body for midwives. When the Health Professionals Competency Assurance Bill becomes law the Midwifery Council will take over the regulation of midwives. Nursing Council policy requires every registered midwife to demonstrate ongoing competency in order to obtain a practising certificate. This policy will take effect in 2001 (following expected legislative change), and the Council has released guidelines for midwives to prepare them for this new system (Nursing Council of New Zealand, 1999). These guidelines were developed by the Council in partnership with the NZCOM.

To obtain a practising certificate midwives are required to provide evidence of their participation in either:

- The New Zealand College of Midwives (NZCOM) Midwifery Standards Review, or
- A recognised midwifery review process

Both processes include the following components:

- Description of individual midwifery practice
- Reflection on individual midwifery practice
- Assessment of practice in relation to the Nursing Council of New Zealand Competencies for Entry to the Register of Midwives
- Evidence of consumer feedback in relation to individual practice
- Involvement in professional activities
- Evidence of ongoing education

Midwives will record this information and evidence in personal professional portfolios and a percentage of midwives will be audited each year to ensure that they are meeting the requirements. Practising certificates are likely to be issued every three to five years, with each midwife likely to be audited once within this period.

Many hospitals throughout New Zealand are already supporting their caseloading midwifery staff through the NZCOM Midwifery Standards review process annually as a way of ensuring ongoing competency, and in preparation for the Nursing Council process. Other hospitals are running in-service education for all midwifery staff about how to establish and maintain portfolios and how to assess individual practice against Nursing Council Competencies for entry to the Register of Midwives. The schools of midwifery and the NZCOM also offer continuing education opportunities for midwives to maintain their competency. NZCOM is currently working with core-facility midwives to refine the Midwifery Standards Review process to meet their specific needs.

Hospital Professional Development Programmes and/or Clinical Career Pathways

For the last several years many of the larger hospitals have developed programmes that measure nursing and, in some cases, midwifery staff competency and skill acquisition and experience in order to identify appropriate levels of practice for staff. These levels are used as a 'credentialling' mechanism through which employers can value, recognise and support staff in their practice development. The framework is intended to provide structured support; learning and feedback to assist nurses and midwives to further develop their knowledge and skills to provide safe and effective client care (Auckland Health, 1999; HealthCare Otago, 2000a).

Most programmes have the following components:

- *Structured orientation and familiarisation* with a preceptor

- *Competencies* described for each level of practice
- Coaching and *structured learning* opportunities integrated into the programme to assist development of expertise
- Processes to assist *reflection on practice* using exemplar and case review
- Consistent feedback using performance management
- Mechanisms for *recognition* of expertise (*level of practice* progression)

(HealthCare Otago, 2000a).

Unlike the NZCOM Midwifery Standards Review process, consumers have not been involved in the development of these models and consumer feedback about midwives is not an inherent part of the processes.

Nurses (and some midwives) are assessed to determine the 'level' of their practice and then are required to present evidence annually to demonstrate that they have maintained this level of competence. They can also apply to move to another level and are required to provide evidence of their practice to substantiate this. There is an expectation that the employer provides assistance to enable the staff member to maintain or develop knowledge and skills.

In some areas the professional development framework used for nurses has been adapted and amended for midwives (Good Health Wanganui, 1999). In these cases the competencies reflect the New Zealand College of Midwives' Standards and the Midwifery Standards Review process is recognised as one mechanism for midwives to review their practice and competencies.

HealthCare Otago is currently attempting to develop a new framework for the professional development of its midwifery staff that fits midwifery better than the adapted nursing models (Health Care Otago, 2000b). This framework recognises that midwives are competent on registration but that midwives do develop their practice over time through experience, ongoing education and reflection on practice. 'Domains of practice' are described in an evolving attempt to describe how this practice might develop and what expectation hospital employers should have of the skills and attributes of their employed midwives in these different domains. By using 'domains' rather than 'levels' HealthCare Otago is attempting to describe a flat structure in which the individual's practice experience and confidence expands while remaining within the scope of midwifery practice and in partnership with women. Unlike the hierarchy implicit in the term 'levels' HealthCare Otago is attempting to recognise that all midwives practice within the same scope of practice but that within the organisation there is a need for some midwives to be confident and experienced in both case-loading and core-facility midwifery and for some midwives to be further prepared for additional roles such as mentor, resource midwife or midwifery practice leader. The competencies described for each domain are based on the NZCOM (1993) Standards for Practice and show how midwives might develop their practice to meet these organisational needs.

Integration of existing processes

The HealthCare Otago Professional Development Programme for Midwives articulates an emerging model of how existing processes can be integrated to ensure the ongoing competency of midwives and public safety. In this model the NZCOM Midwifery Standards Review process is central to the development of a programme that enables midwives to meet the requirements for competency assessment of the Nursing Council, the requirements for competency assessment of the employer, and the requirements for standards review of the professional organisation. By ensuring consistency of requirements and centralising the Midwifery Standards Review process as a mechanism to meet these requirements, midwives are able to complete all requirements effectively and without unnecessary repetition. The programme is not linked to the employment contracts of midwives and processes for assessment of salary reviews or pay scales are separate to the processes for assessment of competency and practice development in the Professional Development Programme.

Issues for midwives

Despite the good intentions of many organisations such as HealthCare Otago in developing professional development programmes appropriate for midwifery, NZCOM still has some concerns.

The midwifery profession has identified its model of practice as a partnership with women. The development of expertise is in partnership with women. Therefore, expertise will differ from partnership to partnership depending on the qualities each woman brings. The quality contract that nursing has developed is around a practitioner moving from novice to expert. Therefore, adaptation of nursing professional development programmes appear to inevitably result in distinctions being made between practitioners and the notion of a hierarchy is implicit even when real attempts have been made to overcome this.

This notion of levels can become even more obvious when professional development programmes are intertwined with employment contract and salary issues as clinical career pathways. For professional development to work best it needs to be about support and ongoing education for the maintenance of competence and development of

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practice. When it is linked to salary it risks becoming a punitive process in which salary increases become confused with professional development.

The question needs to be asked as to why employers want to have these professional development programmes or why they would want a process for credentialling their midwifery employees. The midwifery profession and the employers need to clearly define what it is they want to assess and why. Unless they do there is a risk that any credentialling mechanism, no matter how well intentioned, and regardless of the words used to describe it, could become restrictive and controlling rather than enabling and empowering best practice.

If the purpose of credentialling or professional development programmes is to ensure that organisations have appropriate staff for the various roles in the institution then surely current human resource mechanisms can be used to achieve this. Position descriptions, ongoing support of professional development of staff and annual performance appraisal can achieve the same end for employers.

Any attempt to restrict or redefine the midwifery scope of practice or to privilege certain midwifery skills over others is not in the best interests of midwifery as a whole. The profession has worked hard to develop a model of practice that is based on individual midwife/woman partnership relationships within a defined scope of practice. The midwifery partnership philosophy believes that growth in practice is always reliant on the woman's involvement and this is the area on which midwifery needs to concentrate.

A midwifery model of credentialling

NZCOM believes that processes already exist that allow for the assessment and maintenance of midwifery competencies. The Midwifery Standards Review process provides a mechanism by which the requirements of the employer, the registration authority and the profession can be integrated in one seamless process. This mechanism ensures that all midwives meet the same standards through consistent processes that will enable a high quality midwifery service for the woman and babies of New Zealand.

It is suggested that, rather than develop further credentialling mechanisms for midwives, the Ministry of Health encourage hospitals and other employers to utilise processes already in place. This existing framework, and how it can be used as a credentialling process, is described opposite.

Framework for Competency Assurance for Midwives within hospitals and self employed

Component of credentialling framework	HHS employed midwife	Self-employed midwife claiming from Section 88
Step One **Initial Employment Verification of training, qualifications, experience and registration status**	• Employer checks Annual Practising Certificate (registration details are verified by Nursing Council of New Zealand) • Employer checks referee reports	• Ministry of Health requires Annual Practising Certificate for authorised providers • HHS access to facility agreements require APC and referee reports for access agreement for LMC Midwife
Step Two **The scope of midwifery practice**	• NZCOM and Nursing Council of New Zealand define scope of practice of a midwife • Job description describes position and expectations of employee. This will be either as a caseloading midwife managing an independent practice within the hospital, or as a core-facility midwife working set duties within the hospital • Employer provides orientation process	• NZCOM and Nursing Council of New Zealand define scope of practice of a midwife • Section 88 sets out expectations of Lead Maternity Carer • Access agreement requires orientation
Step Three **Ongoing monitoring of practice**	• Employer requires participation by midwife employees in professional development programme of the hospital • Nursing Council of New Zealand requires competency based practising certificates (maintenance of portfolio and measurement of practice against standards for registration) • Employers can utilise NZCOM Midwifery Standards Review process for caseloading midwifery staff and core facility staff, enabling them to also meet Nursing Council competency requirements	• Self-employed midwives undergo annual Midwifery Standards Review through NZCOM • Nursing Council of New Zealand requires competency based practising certificates (maintenance of portfolio and measurement of practice against standards for registration) • Self-employed midwives can use NZCOM Midwifery Standards Review process to meet this requirement
Step four **Identification of professional development needs**	• NZCOM Standards Review process and Nursing Council competency-based practising certificate process both identify professional development needs for either core or caseloading midwives • Employers can assist midwives to meet these needs in preparation for their next review. This information can form part of the hospital professional development programme assessments and guide employers about ongoing education needs of midwives	• NZCOM Midwifery Standards Review process develops a professional development plan with the midwife under review • Nursing Council competency-based practising certificate process identifies professional development needs • Midwives can undertake necessary professional development in preparation for next review • Local regions of NZCOM provide workshops for midwives guided by their identified professional development needs
Step five **Monitoring process begins again**	• As above for steps three and four	• As above for steps three and four

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Conclusion

As can be seen the NZCOM Midwifery Standards Review process provides a seamless process for ongoing monitoring and assessment of midwives to ensure that midwives remain competent to practise. At the same time this process allows midwives to meet the separate requirements of the NZCOM, the Nursing Council of New Zealand and employers through the one congruent process. Measurement against standards is consistent and midwives are able to see competency assessment as a useful exercise that is also an effective use of their time and has positive outcomes for each midwife.

Rather than developing professional development programmes or clinical career pathways, the NZCOM encourages employers to consider how to integrate their processes with those required by the Nursing Council and the College by utilising the Midwifery Standards Review process.

As a strategy for credentialling, Midwifery Standards Review is very effective and works well for midwives. The credentialling process outlined above provides a positive alternative to the medical model credentialling process and will achieve improved outcomes for hospitals and health services. The midwifery credentialling process is by definition a comprehensive, reflective and educative process based on the midwife's complete scope of practice. It therefore provides for task credentialling but within an holistic, woman centred model involving both the practitioner and the consumer.

REFERENCES

Auckland Health, Department of Nursing and Midwifery (1999). Professional development recognition programme for midwives. Auckland: Author.

Credentialling workshop notes, 17 August, 2001, Ministry of Health, Wellington.

Good Health Wanganui. (1999). Professional development and competency programme for midwives. Wanganui: Author

Health Care Otago. (2000a) Professional development programme for general nurses (Draft). Dunedin: Author.

Health Care Otago. (2000b). Professional development programme for midwives (Draft). Dunedin: Author.

Ministry of Health. (2001). Toward clinical excellence. A framework for the credentialling of senior medical officers in New Zealand. Wellington: Author.

New Zealand College of Midwives. (1995). Midwives handbook for practice. Dunedin: Author.

Nursing Council of New Zealand. (1999). Guidelines for competence-based practising certificates for midwives. Wellington: Author.

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SURFING THE NET

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One of the highlights of this year so far has been the death of my old computer. I was very pleased to have a legitimate excuse to bamboozle my husband into buying me a new computer. This new computer has enabled me to extend my abilities to 'surf' and find new sites that I would like to recommend to you.

The first site is that of the NZCOM 2002 Conference being held in Dunedin. The site includes information about the conference, as well as the facility to register on-line. By the time you read this, the site should include information about accomodation.
www.nzcom.org.nz

If you want to know more about **Dunedin**, I would recommend the following two sites. These sites will help you with finding accommodation, as well as inform you about shopping, restaurants and places of interest to visit, such as the world famous albatross colony.
www.visit-dunedin.co.nz/
www.dunedin-tourism.co.nz

I have just found the **Minister of Health**, Annette King's home page. The site includes a newsletter from Annette called Health Moves in which she discusses the latest news from the Ministry of Health. One of the on-going features of Health Moves will be information given by District Health Boards about initiatives being carried out in their areas.
www.executive.govt.nz/minister/king/healthmoves

For midwives like myself who want to know more about **District Health Boards** (DHBs), the Ministry of Health has a Frequently Asked Questions (FAQs) page. This web page answers questions about the structure and role of DHBs.
www.moh.govt.nz/electionsdhb

I have found a few more web sites belonging to **midwives in** New Zealand.
www.aut.ac.nz/groups/autmidwives

The Auckland University of Technology midwives have a comprehensive site explaining their philosophy and services. I was especially interested to see that there is a facility whereby women can e-mail questions to the midwives. This is very interesting because I have only come across medical sites in New Zealand that offer this facility, such as Xtra's '**Ask the expert**': **www.xtra.co.nz/health**

There's no doubt that there are an increasing number of consumers using the Internet to search for health information, so I'm pleased to see midwives offering women this service. I think it is very important that midwives don't get left behind by the medical profession in this area. Another organisation of midwives with a web site is **Mothers and Midwives Associated**. I liked the information they presented on how to choose a midwife but would have loved to see some photos of the midwives.
www.mama-midwives.co.nz

The **Women's Health Action Trust** is a charitable trust based in Auckland. It's aims are to provide women with high quality information and education services to enable them to maintain their health and make informed choices about their health care. Their web site has a range of links to a number of issues facing women's health such as menopause, contraceptives and hysterectomy.
www.womens-health.org.nz

I have also recently discovered a great site that is more of a newsletter, called **Midwife Info**. Whilst it has a North American emphasis, there are a large number of links that will keep midwives occupied for ages including midwifery education, resources, conferences and practice development.
www.midwifeinfo.com

A very useful resource for **clinical practice** is the 'New Guidelines for Midwife Led Care in Labour'. These guidelines have been developed by Helen Spiby and Jane Munroe, who are midwives in the UK. The guidelines cover issues ranging from supporting women in labour to when to refer to an obstetrician, and were developed from searches of electronic databases and literature, as well as consultation with midwife researchers and peer review.
www.fons.org/networks/ebm/guide.htm

I am very excited because I have acquired a couple of clients through advertising my details on the **NZCOM** web site's 'Search for a midwife'. So to remind you, NZCOM's new web address is:
www.midwife.org.nz

The New Zealand Midwives' **Email List** is under new management. If you wish to subscribe, e-mail Vanessa at: **midwife@kiwinessie.net**

My favourite non-midwifery web site at the moment is supposedly for children but I am absolutely hooked. It has a multitude of games, puzzles, competitions and activities that will keep you and the children entertained for hours, or cause major family fights over whose turn it is to play!
www.neopets.com

CHAPTER CONTENTS

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Developing a midwife-led maternity service: the New Zealand experience

Sally Pairman
Karen Guilliland

INTRODUCTION

Over the last 15 to 20 years the New Zealand maternity service has been reshaped by successive changes in health policy and direction. The maternity service strategy throughout the last 10 years has led to the development and consolidation of a women-centred service in which the emphasis is on choices, access and meeting the individual needs of women and their families through the childbirth experience. The focus of the maternity service has shifted from maternity facilities and the needs of institutions and practitioners to childbearing women and their maternity care needs. This reshaped maternity service entitles every woman to have her own 'lead maternity caregiver' (LMC) and to choose her place of birth. The LMC provides continuity of care throughout the woman's childbirth experience, from early pregnancy through to 4–6 weeks after the birth of the baby. The LMC coordinates the woman's maternity care, in most cases providing all of the care, and accesses and integrates with other services if necessary. The LMC can be a midwife, a general practitioner or an obstetrician.

New Zealand midwifery, under the leadership of the New Zealand College of Midwives (NZCOM), has concentrated on developing a midwifery workforce that can take on this LMC role. The LMC role is ideally suited to midwifery, reflecting as it does the full scope of practice of a midwife, as defined by the World Health Organisation and the International

Confederation of Midwives (NZCOM 2002). Midwives have become the cornerstone of the maternity service in New Zealand. Today over 70% of childbearing women choose a midwife as their LMC and midwifery is a strong and autonomous profession.

The way that maternity services are organised and funded in New Zealand has meant that women and midwives have been able to achieve a level of autonomy in maternity care which in many countries is only possible in non-medicalised settings such as birth centres and at home.

However, strong midwives, a midwifery-led maternity service, partnership with women and professional autonomy are not enough, on their own, to challenge society's construction of childbirth and the continued dominance of the medical model of birth. The socio-political context of childbirth has an enormous impact on how midwives practice, what women understand about birth, how the maternity service develops and what it can achieve. In New Zealand both the midwifery profession and the government have underestimated the power of institutional medicalisation and the impact of the global anxiety around childbirth that is promulgated by the world's media (Health Funding Authority 2000).

NZCOM expected that a strong and autonomous midwifery workforce would be more likely to promote birth as a normal life event within the family context, regardless of the chosen place of birth. The government's vision for maternity states that 'pregnancy and childbirth are a normal life-stage for most women, with appropriate additional care available to those women who require it' (Ministry of Health 2002, p.11). Despite having this midwifery-led service, however, New Zealand's obstetric intervention rates, although showing a slower rise than elsewhere, are now similar to those of most western countries (Ministry of Health 2001).

There are, however, some hopeful signs: midwife LMCs do achieve better obstetric outcomes than the national rates (Midwifery and Maternity Provider Organisation, 'Midwifery outcome data', unpublished report, 2002) and the midwifery-led service has been extremely successful when measured by broader public health and societal changes. For example, breastfeeding rates are high, immunisation rates at 6 weeks are high, informed choice and consent is predominant, consumer satisfaction is high, services are accessible and equitable for most women, Maori women and their babies have significantly improved their childbirth outcomes, the home birth rate has risen from 0.1% in 1989 to 6% in 1999, and costs per birth have been contained within a set budget (Health Funding Authority 1999a, 1999b, 2000, Ministry of Health 2001, National Health Committee 1999, Tracy et al 2002). However, the maternity service overall still reflects the global phenomena of medicalisation and unnecessary obstetric intervention and it will take more than midwifery autonomy to turn this around.

From this strong foundation of midwifery autonomy and midwifery-led maternity services, NZCOM is now turning its attention to developing strategies to decrease unnecessary obstetric intervention and the impact of global medicalisation on midwives and on midwifery care. Of prime importance is the recognition that the place of birth has a strong influence on the outcome of midwifery care. Homes, primary birthing units and birth centres provide contexts in which women and midwives can experience childbirth with less obstetric influence and where physiological birth is more readily achievable. In order to decrease the obstetric intervention rate in childbirth, midwives and women have to regain their trust in birth as a normal and healthy life event. Midwives need to be supported to promote home birth and the use of primary birthing units and to encourage women to choose these options with confidence. It is timely to consider the place of birth centres, particularly in urban areas, as part of these overall strategies.

Through its focus on structural changes to the maternity service aimed at enabling women-centred care, New Zealand has developed a social model for maternity care that is based on midwifery, placing midwives as the key providers in the maternity service. However, New Zealand society's expectations of the maternity service

are still dominated by the medical model of childbirth and the challenges presented by a midwifery-led maternity system have done little to break this down. New strategies for challenging the dominance of the medical model of childbirth include focusing on the place of birth and redefinition of care in childbirth as a primary health service provided in the community. This chapter traces the development of the midwife-led maternity service in New Zealand, highlighting both the opportunities and threats faced by midwifery and the strategies used to deal with these.

ABOUT NEW ZEALAND

New Zealand is made up of two main islands situated in the South Pacific, somewhat closer to Antarctica than to the Equator. It has a population of 3.8 million people, over 70% of whom live in the top half of the North Island. The annual birth rate varies between 56000 and 57000. New Zealand's economy is based on agriculture and consequently there is a large number of rural communities. Some of these communities are small, relatively isolated and inaccessible, due to mountainous terrain and unpredictable climate changes.

New Zealand's indigenous people are Maori and they came to New Zealand around a thousand years ago. Their communities were small and based on a tribal (iwi) system and developed enduring cultural connections to the land. British settlers colonised New Zealand in the early 1800s, initially clearing land and establishing farms. Historically, New Zealand's roots, for both Maori and Pakeha (non-Maori) peoples are agricultural.

This concern for the land, its development and its ownership, was addressed in the Treaty of Waitangi, which was signed in 1840 between Maori and the Crown. This Treaty established the constitutional framework within which both Maori and Pakeha would live and assured the rightful place of each in New Zealand. The principles inherent in the Treaty that govern the relationship between Maori and the Crown are partnership, participation, protection and equity. The partnership is understood to be mutually defined and negotiated on an equal basis, with full participation of both partners and ensuring the protection of each (Ramsden 1990). Despite ongoing disputes between Maori and the Crown in relation to land rights and access to resources under the Treaty, the concept of partnership is now culturally embedded in New Zealand society (Guilliland & Pairman 1995). 'Partnership' is a word often used to describe a variety of social, economic and cultural relationships and is part of everyday language in New Zealand. The development of the maternity services and of the midwifery profession have reflected this social and cultural context of varied geography, extensive population spread and broad cultural mix.

THE DEVELOPMENT OF MIDWIFERY

INDEPENDENT PRACTICE

New Zealand has had a regulated midwifery workforce since 1904 but over the last century the scope of practice of midwives has changed significantly as a result of increasing hospitalisation and medicalisation of childbirth. From working as autonomous practitioners in the early 1900s, midwives gradually became 'assistants' to doctors. From working in the community, midwives began to work mostly in hospitals and within specific areas such as antenatal clinics, the labour ward or postnatal wards, as pregnancy and childbirth became fragmented and 'specialised' (Donley 1986). Through this process many midwives lost their understanding of childbirth as a normal life event and of themselves as 'guardians' of the normal birth process. Instead, they experienced highly interventionist and medicalised maternity care, directed by the doctor and the hospital. Legislative changes over the years also decreased the scope of midwifery autonomy and midwives were required to work under the supervision of a doctor. Thus it was that when midwifery autonomy and the full

scope of midwifery practice were finally regained in 1990 (through changes in legislation) it was necessary to re-educate the midwifery workforce to believe in and to be able to provide a service for normal birth.

In New Zealand it was primarily women who rebelled against the hospital-directed model of childbirth and demanded the return of the 'traditional' midwife–one who would be alongside them throughout the whole experience, from early pregnancy through to 6 weeks after the birth of the baby. They wanted midwives who would believe in their abilities to give birth without medical intervention and who would support them in reclaiming childbirth as a normal life event. New Zealand women wanted to take back control of their birthing experiences and to take their rightful place at the centre of events rather than be passive bystanders at their own birthing experiences. In the 1980s midwives joined with women in their fight to reinstate the autonomy of midwifery and together they carried out a very successful political campaign that culminated in legislation in 1990 that secured the professional autonomy of midwives.

The model of midwifery that has developed in the decade since that legislation was passed is one of independent practice and partnership between the midwife and the woman. Contrary to practice in countries such as the United Kingdom and Australia, independent midwifery in New Zealand is not related to income, employment or place of practice, but to *how* a midwife practises. 'Independence' is intended to mean autonomous midwifery practice in which the midwife carries her own caseload of clients with responsibility for all their care from early pregnancy through to 4–6 weeks after the birth. When problems arise midwives consult with obstetricians, who provide any necessary obstetric care. Just under half of all New Zealand midwives now choose to work in this way, as independent practitioners (New Zealand Health Information Services 2001). The midwife is not independent of the public health system (as in the UK where an independent midwife charges the woman a fee privately for care), rather the midwife is independent in her practice and is able to make autonomous and professional midwifery decisions. Neither is independence about employment status. In New Zealand independent midwives may be self-employed (paid directly by government) or employed (paid by a hospital) and may care for women in any setting, including home, small (primary) maternity units and secondary and tertiary hospitals. The defining characteristic of all these midwives that makes them 'independent' is that they independently manage their own caseload of clients throughout the entire childbirth experience.

Although the midwife is professionally independent, she does not work in isolation. Generally midwives work in partnership with other midwives and in collaboration with any other health professionals the woman requires, such as doctors or social workers. Most importantly, the midwife is never independent of the woman and in fact works in a unique partnership model with women. We will discuss this partnership relationship shortly. At any one time, an independent midwife (employed or self-employed) may have clients expecting to birth at home, in a small unit or in a base maternity hospital and midwives move in and out of these settings as their clients' needs dictate. All maternity care, except private obstetric care, is free to women.

Over the last ten years the maternity services have changed dramatically as a result of midwifery autonomy and the reshaping of the structures of the maternity service that arose in response to this new group of maternity care providers. The reshaped maternity service is ideally suited to the role and scope of practice of midwives, as they are able to provide all aspects of the maternity service specifications. General practitioner and obstetrician LMCs, on the other hand, do not traditionally provide labour care or postnatal care and they are required to make documented arrangements with a midwife for the provision of this care. Midwives have embraced the opportunity to work within the full scope of midwifery practice with enthusiasm. Nearly 50% of the midwifery workforce now works independently. The majority of these

midwives are now community-based and self-employed in that they claim directly from a centralised funding mechanism. The rest are employed in hospitals but practice independently as LMCs in the independent midwifery services that have been set up in most base maternity hospitals throughout New Zealand.

This development of employed midwife LMCs was driven by three separate factors. Firstly, hospital midwives demanded that they should be able to work within the full scope of midwifery practice. Secondly, the provision of this type of midwifery care gave the hospitals access to another funding source–as well as their funding for secondary maternity services, the provision of an independent midwifery service meant that hospitals could also claim from the primary maternity budget on behalf of their employed LMC midwives. Thirdly, hospitals were required to rethink how midwives worked within their institutions when many of their experienced midwives left to establish themselves as self-employed practitioners in the community. Some hospital managers understood that in order to recruit and retain the staff with the mix of skills required to run a hospital maternity service they had to give their employed midwives the opportunity to practice midwifery in the full sense of the word. It also required them to increase salaries and wages if they were to compete with the self-employed midwives' income potential.

The majority of women today receive care from a midwife throughout pregnancy, birth and the postnatal period; previously, continuity of care was only available in a limited way for those few women who chose to have a home birth (Health Funding Authority 2000). Now, instead of doctor-led care being the only option, some 70% of women choose midwifery-only care (Health Funding Authority 2000). Instead of medically controlled maternity services, women expect, and are legally entitled to, information and the right to make informed decisions about their choice of carer, their style of care and their place of birth. Instead of hospital services based around the needs of the institution and the health professionals, there is an expectation of maternity services based on the needs of women and their families. This means choice and control for women and their families; access to services for families; recognition and support for the primary midwife–woman relationship from the institution; antenatal and postnatal visiting in the woman's home; and short stays in hospital with postnatal follow-up in the community. Increasingly, New Zealand society is regaining its recognition of the midwife as the primary practitioner in normal childbirth.

This development of professional autonomy and the full scope of midwifery practice has required significant support for midwives from the wider midwifery profession. The New Zealand College of Midwives has set standards for practice, a code of ethics and guidelines for practice (NZCOM 2002). NZCOM has offered ongoing education to midwives and has worked closely with the midwifery educational institutions to ensure that a range of appropriate programmes is available, from pre-registration courses through to Masters of Midwifery. A Midwifery Standards Review Process has also been developed by the College.

Midwifery Standards Review

Midwifery Standards Review evolved from a process originally developed by home birth midwives in 1987. It is a confidential, intensive, reflective process that aims to educate and support the midwife to develop her practice in a positive way. It enables LMC midwives to review their practice each year with a panel of two midwifery peers and two consumers. The midwife provides an analysis of her year's work, her statistical outcomes and her self-evaluation against the NZCOM Standards for Practice and the feedback from the consumer questionnaires completed by her clients. The panel provides feedback and support for the midwife. It helps her to draw up a professional development plan for her next year of practice. A unique aspect of this review is the equal participation by consumers in the review process and the mechanisms that have been put in place for consumer feedback from the midwife's clients.

The NZCOM Midwifery Standards Review Process is a central strategy in the professional development of LMC midwives. The College is currently developing a Midwifery Standards Review Process for core midwives who do not have a caseload of clients. The intention is to support all midwives as they develop confidence in their clinical judgement and to emphasise midwifery's specific body of knowledge, so enabling them to feel more secure in their independent midwifery role.

The NZCOM Midwifery Standards Review Process is recognised in the Nursing Council of New Zealand competency-based practising certificate requirements (Nursing Council of New Zealand, 1999). The Nursing Council is currently the regulatory body for midwives although new legislation due to be enacted in 2002 will create a Midwifery Council and finally bring midwifery regulation under the auspices of the midwifery profession itself. The Nursing Council, in partnership with NZCOM, has established a competency-based practising certificate regime that requires all midwives to demonstrate that they continue to meet all the competencies required of an LMC midwife on registration. Midwives can demonstrate these competencies through a portfolio mechanism that is similar to that required for midwives in the United Kingdom. Alternatively, midwives can also meet the competency requirements by undertaking the Midwifery Standards Review Process. Both processes require midwives to demonstrate that they meet the standards of the midwifery profession and that they can provide independent midwifery care, in partnership with women, throughout the whole scope of midwifery practice.

MIDWIFERY PARTNERSHIP

The midwifery model that underpins the New Zealand maternity services today is one of partnership between the midwife and the woman. This conceptual framework mirrors the intentions articulated in the Treaty of Waitangi in that the relationship between the woman and the midwife is seen as an equal one, and one to which both partners make equally valuable, but different contributions. Partnership, and in particular the notion of equality in partnership, is a deceptively simple concept. However, like all human relationships, partnership requires a complex set of conditions to be successful. Cultural, economic and social differences between 'partners' can interfere with their ability to understand each other's perspective. These differences need to be acknowledged and worked through to an agreed position. Communication and negotiation are skills and processes fundamental to partnership.

The midwife brings her professional knowledge, skills and experience of pregnancy and childbirth to the partnership relationship. The woman brings her knowledge of herself and her family, together with her needs and wishes for her pregnancy and birth. Over the period of the pregnancy the woman and the midwife get to know each other and to trust each other. They talk about their expectations of each other, they talk about how the pregnancy is progressing, they talk about options for care and the decisions the woman will need to make. The midwife offers information, a specialised midwifery knowledge base, and support for the woman in making informed decisions about her care. The woman remains in control of her birthing experience, making decisions about how she wants it to be. The midwife stands alongside the woman in a supportive role. She guides the woman and supports her decisions but does not take control. The power balance between them is negotiated and equitable. They share responsibility for what happens and for the decisions they make. This increases the self-determination of both and reinforces the midwife's understanding of her role in the partnership. The relationship is therefore reciprocal.

It is these concepts of reciprocity and equality that have been the most difficult for midwives and women to understand and to implement. Society is still dominated by the view that the health professional is always the expert, that the patient (or woman) is the passive recipient of this expertise and that therefore the relationship between them is always unequal. At the other

extreme, the constitutional right of women to informed choice and shared decision-making has at times been used as a reason for health professionals to abdicate responsibility for making professional judgements. For example, the right to choose has, in some cases, led to women choosing to have unnecessary obstetric intervention (e.g. induction or elective caesarean section) in the absence of any clinical indication.

In the midwifery partnership model both the woman and the midwife retain responsibility for their individual decisions and the midwife, as a health professional, is expected to apply her professional knowledge base. For both the woman and the midwife the concept of partnership is premised on their autonomy, their ability and their right to make decisions together and their ability and their right to take responsibility for those decisions. Partnership involves a shift of power from the health professional to the woman in the same way that the midwife's allegiance moves from the hospital or doctor to the woman as she supports her and stands alongside her through the process of pregnancy and childbirth. For the partnership to be successful midwives need to have a real knowledge of their support role. Midwives and women have had to learn about this partnership relationship through experience and reflection on these experiences. Midwives and others have begun to write about partnership and to share this developing understanding and knowledge with the midwifery profession (Guilliland & Pairman 1995, Daellenbach 1999, Pairman 1998, 1999, Skinner 1999).

Midwifery education programmes in New Zealand have paid considerable attention to ensuring that midwives understand partnership. Midwives have a responsibility to ensure that professional autonomy does not mean merely the assumption of the power previously wielded by institutions and medicine over women. Equally, emphasis has been placed on midwives' understanding of informed decision-making–that it does not mean that they can opt out of their professional obligations and their responsibility to utilise their midwifery knowledge in practice (Pairman 1998, Tully et al 1998). Midwifery curricula teach that the aim of the midwife is to support each woman in reaching her full potential and in experiencing a positive, safe and fulfilling childbirth. The underlying philosophy of this midwifery education is that if women have control over their birthing experience they will have more confidence in themselves as mothers and that this, in turn, will have a positive effect on children, on families and on society at large (Otago Polytechnic 1999).

This midwife–woman partnership is now the basis for midwifery services in New Zealand. For New Zealand midwives, partnership with women defines their professional status. Significantly, this partnership model extends beyond the individual midwife–woman relationship, and partnership is embedded culturally, both within the agencies of government and the overall structures of the health service. This meant that when the maternity service was restructured in the mid 1990s there was an understanding at both government and health-provider levels that the service would need to be based around women and their families, and recognition of their right to be involved in their own maternity service.

FUNDING FRAMEWORK FOR MATERNITY SERVICES

The maternity service in New Zealand consists not only of the care provided to women and babies but also the locations in which that care takes place. The unique funding mechanism for the maternity service has directly influenced service development in relation to practitioners and to place of birth.

Since 1938 New Zealand has had a state-funded social security health system that includes a fully funded maternity service that is free to women. This funding is centralised and, initially, a set of fees was established on the Maternity Benefit Schedule for each consultation with a general practitioner or obstetrician. (Private obstetricians were the only practitioners able to make charges on top of these set fees).

The Nurses Amendment Act 1990 reinstated the midwife as an autonomous practitioner who no longer required the supervision of a doctor. It enabled midwives to claim fees from the Maternity Benefit Schedule on the same fee-for-service basis as doctors and at the same rate. It also brought a new element of choice and competition to maternity service provision in that women could now choose between a midwife, a general practitioner or an obstetrician for their maternity care.

The neo-liberal economic influence on government policy in the 1990s was the impetus for extensive health reforms carried out through those years (Gauld 2001). With the underlying emphasis on competition, profit making and contracting for services, the health reforms presented midwifery and the wider maternity service with both opportunities and problems. The Government used the new context of competition between midwives and doctors that resulted from Nurses Amendment Act 1990 to initiate reforms to the Maternity Benefit Schedule. Midwives were new players, providing a different maternity service from that provided by doctors, and could be used as a lever to change the overall funding mechanisms. While supportive of choices for women, the Government's primary aim was economic in that it wanted to move from fee-for-service payments on demand, to a capped budget for a specified set of services. It also understood, however, that if any change was to be successful in the prevailing social context, it would need to reorganise the maternity services around a woman-centred base.

The New Zealand College of Midwives, with its consumer partners, recognised that the way in which maternity services were funded was the key to realising the opportunities that the Nurses Amendment Act 1990 gave for autonomous practice. While this legislation had given midwives equity of pay with doctors and had enabled them to claim from the Maternity Benefit Schedule, it was just the first step. Initially, only a few midwives left hospital employment and many of these were obliged to provide 'shared care' with doctors, as general practitioners were still perceived as the gatekeepers to the maternity services. Most midwives remained employed by hospitals, where their main role in primary care was providing labour and postnatal midwifery services for clients of general practitioners–much as the role of the hospital midwife had always been. The reshaping of the maternity services funding mechanism provided an unprecedented opportunity not only to develop and reclaim the midwife's role in the provision of primary maternity services but also to reinstate pregnancy and childbirth as a community-based life event. Equally, without strong midwifery representation from NZCOM and consumer lobbying, the role of the midwife could have been subsumed into medical and hospital contracts and the opportunity for radical change lost forever.

The College spent 3 years, from 1993 to 1996, in negotiations with combined regional health authorities and the New Zealand Medical Association (NZMA) that resulted in the drawing up of a national framework for the provision of maternity services. Primary maternity service funding and service specifications were set out under Section 51 of the Health and Disability Services Act 1993 (commonly referred to as 'Section 51'). Section 88 of the Public Health and Hospitals Services Act 2001 later replaced this. There was also a national framework for the funding of secondary and tertiary (complicated) maternity services, allocated on a population base, and a separate national framework for the funding of the maternity facilities in which birth takes place. This is available for primary facilities (birthing units), secondary facilities (maternity hospitals) and tertiary facilities (maternity hospitals with high-technology facilities). Home birth is funded through the primary maternity services funding framework.

PRIMARY MATERNITY SERVICE FUNDING

Section 51 of the Health and Disability Services Act (and later, Section 88 of the Public Health and Hospitals Services Act 2001) set out the mechanisms for funding primary health services

such as the general medical services provided by general practitioners and primary maternity services provided by midwives, general practitioners and private obstetricians. In New Zealand 'primary health' refers to the first level of contact within the health system. It is universally accessible and involves community participation. It covers a broad range of services, including health improvement and preventive services; first-level generalist services such as general practice and pharmacy; and first-level services in more specialised areas such as maternity, family planning, dentistry and sexual health (King 2001).

The placement of the maternity services within a primary health framework has led to the recognition that pregnancy and childbirth are parts of one life event and continuity of care is the cornerstone of the new system. Moving on from a maternity service that was fragmented, with antenatal care in general practice clinics and birth and postnatal care in hospital, with a variety of carers, the new structure integrates all aspects of the maternity system in order to meet each woman's individual needs. This integration of service provision between primary and secondary care has required that the historical boundaries of service funding be revisited as the distinctions between primary and secondary services have become increasingly blurred. The new model of women-centred continuity of care requires that practitioners cross the traditional boundaries between the community and hospitals as they seek to ensure that the woman has access to all aspects of the primary and secondary maternity services that she requires.

Under Section 51 (and now Section 88) primary maternity funding is attached to four modules of care with the expectation that all four modules will be provided by the same carer. Fee-for-service payments remain for care provided in the first trimester and for consultations with obstetricians and other specialists. Modular payments are made for the second trimester, the third trimester, labour and birth and for the postnatal period (up to 4–6 weeks). The woman must choose a lead maternity carer and this person is then responsible for providing and/or coordinating all necessary care throughout the whole experience. The LMC is the constant in the system, as the provision of continuity of care requires the LMC to move with the woman, facilitating her access to any additional services that may be required.

Midwife LMCs work in the community, visiting women in their homes or in clinics during the antenatal period. During labour and birth the LMC attends the woman in the place of her choice–home, primary birthing facility or larger hospital–and provides her labour and birth care. In the postnatal period the LMC midwife provides care through to 4 to 6 weeks, either totally in the woman's home or initially with hospital visits if the woman has chosen a hospital birth and postnatal stay in hospital. At any stage the LMC midwife may consult with an obstetrician if required and the obstetrician may provide intervention if necessary. The woman may therefore need to access secondary maternity services on an episodic basis, although the LMC remains involved with the woman's care and responsibility for the woman's care is transferred back to the LMC when the need for secondary services is over.

This integrated service has meant that midwife LMCs provide care to a whole range of women with varying risk factors–they do not only provide care to low-risk women. Instead, they are available to all women, recognising that some women will require additional involvement from a specialist. This woman-centred and continuity model has required all maternity providers to re-examine their relationships and their traditional boundaries. New ways of working have had to develop. The funders of maternity services and the managers of maternity facilities have also had to work through the implications of this new model and the traditional boundaries between primary and secondary services have had to be challenged.

Primary maternity facility funding

New Zealand's primary maternity facilities accommodate approximately 10% of the total annual births (Ministry of Health 2001). A primary maternity facility is defined as one that

provides 'inpatient services during labour and birth and the immediate postpartum period until discharge home. They may also be referred to as level 0 or level 1 facilities.' (Health Funding Authority 1999b). The primary facilities have no access to on-site medical and obstetric specialists. Historically, these facilities were known as 'general practitioner units' or 'cottage hospitals'. In line with overseas trends there has been an exodus of general practitioners from obstetric services and these facilities have now become midwife units (Guilliland 1998). In some rural and provincial areas general practitioners still provide a back-up service for medical emergencies, but in most rural areas midwives provide the only maternity service available to women. Only six primary facilities are actually called 'birthing units' and these do not provide inpatient postnatal care, being opened up by the midwife when a woman arrives for labour and birth and closed again once the woman transfers back home (Health Funding Authority 1999b).

Primary maternity facilities in New Zealand resemble what are known in other countries as 'stand-alone birth centres'. However, there are no specific booking criteria and practitioners make decisions with women on an individual basis on their suitability for birthing in these facilities, in accordance with generic guidelines for referral to specialist services (Ministry of Health 2002).

There are 52 primary maternity facilities in New Zealand, some of which are stand-alone and some of which are attached to community hospitals. There are no birthing centres attached to secondary or tertiary hospitals in New Zealand. For the most part, primary maternity facilities are located in provincial and rural areas as most major centres lost their primary maternity facilities in the drive for centralisation of obstetric services to the main teaching hospitals that occurred in the 1970s and 1980s (Donley 1986). Only two of our major cities have primary maternity facilities that survived: Auckland City has three units and Christchurch has retained five, in part due to a strong consumer lobby lasting over many decades. The survival of primary maternity facilities in provincial and rural New Zealand, particularly in the South Island, is mainly due to geographical factors and the difficulty in ensuring access to main centre hospitals.

In the mid-1990s the competitive funding and contractual culture created an opportunity to establish new primary maternity facilities. For a short time, funding for health services became contestable and available outside the traditional hospital-controlled contracts. A few innovative midwives took up this opportunity. Midwife-run birthing facilities were established in the cities of Hamilton (Riveridge) and Christchurch (Avonlea) and in rural Alexandra (the Charlotte Jean Birthing Unit). These midwives were able to access maternity facility funding for their buildings through the national primary facility contract and their LMC midwifery services were funded through Sections 51 and 88. As will be discussed later, the funding of these midwife-led facilities is now under threat unless alternative sources of funding can be found.

Despite geographical difficulties and the distance of the primary facilities from specialist services (commonly 1 to 2 hours away), there is no evidence that maternity care in primary maternity units is detrimental to the outcomes for women and babies (Ministry of Health 2001). The average normal birth rate in primary facilities is 92%, with the majority achieving over 96% (Ministry of Health 2001). The antenatal assessment and referral system is well developed and facilitated by a set of specialist referral guidelines negotiated in conjunction with the Section 51 structures of 1996 and again in 1999 (Ministry of Health 2002). New Zealand's neonatal and maternal outcomes are in line with most western countries, which suggests that LMC referral patterns from the relatively isolated primary facilities to the secondary services are both appropriate and timely (Ministry of Health 1999, 2001). For example, it is known that in-utero transfer rates of over 90% are associated with improved neonatal outcomes for preterm labour before 32 weeks gestation–LMCs using New Zealand's primary facilities achieve a 97% in-utero transfer rate for this group (Ministry of Health 2001). Overall, New Zealand's preterm

labour rates have decreased since 1990, as have admissions to neonatal units (Ministry of Health 1999).

Despite the accessibility and safety of primary maternity facilities, the number of women choosing to birth in many of these units is decreasing. Part of this decrease may be explained by a 6% rise in home birth rates, but there are probably a number of interrelated reasons. These include declining birth rates overall and a population drift from rural to urban centres. This is compounded by the exit of general practitioners from obstetric services and denial of access to facilities for some midwife LMCs by hospital managers who still believe that there must be a doctor present at every birth. LMC midwives may also be faced with inconsistent obstetric opinions when they ask for a second opinion or consultation from obstetricians, many of whom view birth in primary facilities as unsafe and recommend that the woman birth in a secondary facility.

General practitioners, obstetricians, midwives and the women themselves are all influenced by an increasing climate of fear of birth in society. The medical profession is increasingly citing medico-legal risk as a reason for denying women the choice of non-interventionist birth in a place of their choosing (Cunningham and Dovey 2000). This reasoning lacks support from any New Zealand case law as New Zealand is in the enviable position of having accident compensation insurance for all members of the public. In return for this insurance New Zealanders do not have the right to sue their health practitioner (New Zealand Government 1998). Finally, midwives themselves, for reasons similar to those of the doctors, often bypass primary facilities and take their clients to secondary facilities to birth.

From a midwifery perspective this decline in the use of primary maternity facilities is disappointing, given that these units enhance opportunities for independent decision-making, continuity of care and normal birthing. Because primary facilities rely completely on midwives to provide the service, it is imperative that the midwifery profession encourage midwives and their clients to support these units if they are to survive. In rural areas primary maternity facilities can fulfil several functions in the community. They are part of the traditional health services and many communities have incorporated other services within the facility such as care of the elderly and child health services.

Proponents of home birth argue that primary facilities offer no more guarantees of safety than birth at home. This is true. However, they may provide 'psychological' security for some women. In urban areas in particular, primary maternity facilities can provide an extremely important 'half-way position' for women and midwives who have experienced generations of highly medicalised maternity services. The move from secondary facilities to home birth is too great for most women and for most midwives used to a medicalised service. It is for these reasons that the New Zealand College of Midwives has begun to investigate the possibility of developing stand-alone birth centres in urban areas where there are no primary facilities. It is also working on strategies to increase the usage of the primary care facilities already in existence (NZCOM, Quality plan 2001–2003, unpublished, 2001).

Home birth

For LMC midwives who are grounded in normal birth philosophy, home is the ideal place for women to give birth. The new maternity structure under Section 51 (Section 88) has provided very favourable conditions for women to give birth at home. Home birth is now a mainstream option, offered and funded alongside all other birth options. Funding has been designated, in recognition of the savings made to facility funding by home birth. LMCs are required to provide a specified maternity service but this requirement is not linked to place of birth. Midwife LMCs can therefore provide care to women in all settings and many have begun to offer home birth services. Since women have been able to choose this option the home birth rate has risen to approximately 6% of the annual birth rate, a figure not too dissimilar to the 10% achieved by primary birth facilities (Health Funding Authority 1999b, Ministry of

Health 2001). For some rural midwives the choice of home birth by women may pose a dilemma as it may threaten the viability of the primary facility–these facilities are mostly funded on a per capita basis. In some areas where primary birthing facilities have closed, such as the central North Island, it is interesting to note that home birth rates are as high as 12% (Midland Region Health Funding Authority 1998). This may reflect the presence of a high Maori population in this area as Maori women generally are more likely to experience normal birth and tend to view birth at home more favourably than Pakeha women (Ministry of Health 2001).

Birth at home and birth in primary maternity facilities are two strategies that are easily available to midwives in their bid to reduce the escalating obstetric intervention rates that are typical of the secondary facilities.

SECONDARY SERVICE AND FACILITY FUNDING

Section 51 primarily funds the LMC continuity service for all women. It also funds private specialist consultations. There is separate funding for hospital-based secondary services, including hospital specialist consultations. This is intended to ensure that there is no financial disincentive for LMCs to delay consultation or referral to obstetric services if necessary. Secondary maternity services provide 'additional care during antenatal, labour and birth and postnatal periods for mothers and babies who experience complications and have a clinical need for referral to the secondary maternity service' (Health Funding Authority 1999b). Secondary maternity hospitals are also referred to as 'level 2 hospitals' and they provide access to obstetricians, anaesthetists, paediatricians and other medical specialists employed by the hospital and a core midwifery service. The core midwife has become important in the development of the partnership model of midwifery practice as she facilitates communication between the primary and the secondary services for both the woman and the midwife LMC.

With the implementation of the LMC model, the majority of women who choose to birth in hospital arrive with their own midwife who provides their labour and birth care and who is on call 24 hours a day for their postnatal care. This has led to a change in the way that hospitals staff their maternity units and redefinition of the role of those midwives who choose to be employed in the various areas of the maternity hospital on a rostered basis. The rostered midwife staff numbers have decreased significantly, particularly in labour wards. The main role of these core midwives in primary birth is to provide midwifery services for general practitioner or obstetrician LMCs and, in most hospitals, to facilitate the midwife LMC/woman relationship by supporting the midwife LMC in the hospital environment (Campbell 2000). In labour they provide a welcome second pair of hands, relieve LMC midwives for breaks during a long labour and are available to the LMC for discussion and midwifery peer support. All core midwives also provide a secondary midwifery service when LMC midwives have transferred care for an episode of intervention. In antenatal and postnatal areas core midwives work with the LMC and the woman in developing the woman's care plan and deciding who will provide particular aspects of the care.

When a woman requires secondary care and the services of an obstetrician or other specialist, the LMC midwife is still paid from Section 51 (88) for the midwifery service. She is therefore able to provide continuity of care to all her clients, regardless of their risk status. However, if the midwife feels that the woman's care is outside her scope of practice she is able to transfer that woman's care to the core midwife in the hospital, although she may choose to stay on as a support person and work with the core midwife. Generally, the woman's care is transferred back to the LMC midwife once the need for additional services or obstetric intervention has passed.

Secondary hospital facilities

Most of New Zealand's secondary care maternity hospitals were built in the 1960s and reflect the fragmented, interventionist maternity care model of the time, with separate antenatal,

labour and postnatal wards. The labour wards were also separated into rooms for labour and theatres for birth. During the 1980s, as a result of consumer pressure, cosmetic changes were made in an effort to make the facilities more 'home-like'. During the 1990s the new focus on continuity of care provided the impetus for most facilities to reorganise their labour wards as a series of birthing rooms. In many areas these birthing rooms are fitted out in a similar way to birth centres in other countries. They are large enough to accommodate families, emergency equipment is hidden and many have 'normal' beds and other furniture. Most hospitals have some form of water immersion available for women who choose to labour in water and increasing numbers of hospitals are installing birth pools.

Most secondary maternity facilities are old and scheduled for rebuilding. New maternity facilities are now being purpose-built to reflect the new maternity service model, with few antenatal and postnatal beds and with large family birthing rooms. The difference between these large family birthing rooms in New Zealand's maternity hospitals and those in birth centres in other places is that these rooms are available to all women, regardless of risk status. There are no booking criteria. The facilities in new maternity hospitals are designed to accommodate women and their families during labour and to fit in with the women-centred and continuity of care model of maternity care available to all women in New Zealand.

THREATS AND OPPORTUNITIES

For a short period of time in the competitive climate of the mid-1990s it was possible to contract outside of the national Section 51 maternity framework. This policy shift was based on the market model ideology, that competition between health providers will result in cheaper health services and will also shift responsibility for these services from the state to the individual health provider (Gauld 2001). The medical profession saw this competitive contracting arrangement as an opportunity to become the budget-holder for the total primary health budget and therefore the gatekeeper to all health services. Individual general practitioners rapidly grouped to form medical independent practitioner associations (IPAs). The government of the day funded and encouraged the IPAs to bid for health service contracts on behalf of their members in areas such as laboratory and pharmaceutical services and well child and sexual health service provision. The ability of IPAs to cost-shift within these many and varied contracts gave them a major financial advantage when it came to maternity funding.

Several IPAs were successful in gaining contracts for maternity services that were outside the Section 51 framework. These contracts created a number of potential threats for midwifery and the wider maternity service. Firstly, they pitted midwives against each other as some midwives joined the medical IPA maternity contracts and doctors were able to obtain midwifery services for 'shared care' arrangements at a cheaper price than they would through Section 51 arrangements. Secondly, they undermined the LMC model of maternity care as the IPA arrangements invariably replicated the doctor-dominated model that had existed prior to 1990 in which care was given by a number of providers, leading to reduced continuity for the woman. Thirdly, they threatened the financial stability of individual midwife LMCs as these contracts were funded by surplus money that would normally have been channelled into Section 51. Over time, Section 51 became significantly underfunded in comparison. Fourthly, these contracts were awarded with no requirement for reporting maternity outcomes data into the national maternity dataset. The first national data available on maternity services outcomes in New Zealand therefore do not include some 30% of births that came under these alternative contracts (Ministry of Health 2001).

During this period of competition it was difficult for the midwifery profession to know whether Section 51 would survive as a national funding mechanism or whether maternity funding would eventually be split into a number of

smaller contracts. The New Zealand College of Midwives strongly favoured the continuation of a national funding mechanism because it ensured a consistent fee for midwifery services throughout the country and, more importantly, because the national framework and LMC model supported midwifery autonomy.

The College developed two main strategies in response to this competitive environment. The first was a pragmatic approach. If the national Section 51 framework were to disappear, midwives would need another mechanism by which to contract for maternity services and so NZCOM also sought a contract outside of Section 51 and formed its own service-contracting organisation, the Midwifery and Maternity Provider Organisation (MMPO). This organisation provided a payment mechanism for its midwife members, receiving contract money for its maternity service and passing this on to the midwife members. Initially, only midwives working in the South Island of New Zealand were able to use MMPO and its operation remained quite small, while most midwives were able to continue to claim from Section 51. Its main purpose, however, was to provide an alternative that could be used by midwives if Section 51 were to be removed as a national funding framework in the future.

The College's second strategy was to mount a concerted campaign to re-establish the national funding framework for maternity care and to increase the level of its funding. The College was supported in this strategy by various women's groups who, like the midwives, believed that standardisation of funding would lead to more equitable access for women. The College argued that all contracts outside Section 51 should be cancelled and that all maternity funding should return to the national framework, with any additional monies being used to increase the overall level of funding within Section 51. The College realised that this would require the cancellation of its own contract through MMPO as well as medical IPA contracts. Other potential casualties were the few midwifery groups that had negotiated primary facility funding to establish midwife-led birthing units or midwifery-led service contracts.

This strategy has been successful and the Ministry of Health is currently in the process of bringing all contracts back into the Section 51 (Section 88) national framework, which has also received a significant increase in overall funding.

However, for the fourth time since 1983, the New Zealand health system is undergoing another major restructuring (Gauld 2002). This time, 21 District Health Boards (DHBs), made up of both appointed and community-elected representatives, will be responsible for the provision and funding of integrated health services within their regions. The centralised maternity funding mechanism will eventually be devolved to these DHBs and, once again, the maternity system risks fragmentation and regional variation in services. The newly evolving DHB system poses either another threat or an opportunity for the midwifery profession. Midwifery will be able to retain control of its own services through a more powerful national MMPO, which will contract with each of the 21 DHBs to provide midwifery services for primary health. If the DHBs do not take up this opportunity but defer to IPAs or other primary health organisation structures, midwifery again faces a considerable risk of losing its professional independence. Women would also return to the kind of fragmented, multi-provider system that existed before 1990.

Even in its short lifetime the College of Midwives has already experienced a similar threat. The rapid demise of the national Section 51 contract in the mid 1990s and its replacement by non-uniform provision, dominated by medicine, was a salutary reminder to midwives that their position would always be vulnerable if they did not remain collective in their political actions and in their funding negotiations. The overriding philosophical understanding of NZCOM is that the entire midwifery profession needs to be in a position of strength, rather than just a few of its individual members. Putting midwives into a position of having to compete against each other is detrimental to the profession as a whole and also results in inequitable provision of services to women. A consistent level of funding for all midwives is more likely to achieve an egalitarian service for women.

With this in mind, NZCOM has refocused on the Midwifery and Maternity Provider Organisation. The MMPO can provide a national structure to which midwives can belong and to which the DHBs can contract in order to access midwifery services for their regions. A national approach strengthens the midwifery profession and is more likely to ensure consistency in the funding and provision of midwifery and maternity services throughout New Zealand. As well as providing a collective negotiating tool for midwives, MMPO offers a practice management system that will be available to all midwives throughout New Zealand and will encourage a collective approach to financial and business management for self-employed midwives. The development of this strategy to maximise the opportunities and minimise the threats of this current health system restructuring is a priority for the College.

Alongside this strategy is the recognition by midwifery that primary birthing facilities provide an important focus for normal birthing and independent midwifery services. While New Zealand has not had to develop birth centres as a way to achieve midwifery autonomy and normal birth services for women, the time is now right to work on developing birth centres (primary maternity facilities) in order to protect and strengthen midwifery autonomy and the women-centred services that already exist. Midwives and women need locations for birth that are not dominated by the medical model philosophy of birth. They need to strengthen their understandings of birth as a normal physiological process and they need to reduce their reliance on technological intervention for routine screening and pain relief. It is only by relearning about normal birth and understanding the impact that medicalisation has had on their attitudes and practice that midwives and women will be able to bring about any reduction in obstetric intervention rates. And it is through women and their families that fundamental changes in society's understanding of childbirth will occur. The place for this relearning is in the home and in primary maternity facilities or birthing centres. It is time for the New Zealand maternity service to actively promote both home and primary facilities/birthing centres as the most appropriate places for the majority of women to give birth.

CONCLUSION

This chapter has attempted to trace the history of midwifery and the place of birth in New Zealand within the context of repeated changes in the country's health system. There is no single factor that guarantees the realisation of the ideal maternity or midwifery service. When midwives in New Zealand regained autonomy in 1990 they thought that a midwifery-led service would be relatively easy to achieve. What they failed to recognise was the energy and political acumen that would be required to maintain the midwife's position within the maternity service. The midwife's position is really only important to midwives and to the women who have experienced the difference a midwife can make. The maternity system is much more strongly influenced by the wider health system and by external factors such as economic and political priorities. Maternity services are only a small part of the overall health system and changes in the wider system may have unexpected consequences for midwifery and maternity. The New Zealand midwifery profession has realised that in order to maintain a stable midwifery and maternity service it needs to become embedded in the political system. It must remain constantly vigilant, recognising opportunities and threats as they arise.

Historically, New Zealand has looked overseas for models of health that have worked and New Zealand midwifery has adapted a largely British model. Its biggest adaptation has been in its workforce development, working towards a self-employed business model of autonomous midwifery practice. It is this ability to be both self-employed and autonomous in her practice that has allowed the New Zealand midwife to tailor her service to individual women. She is able to care for all women, regardless of their risk status, and can work with women in all settings. Under the funding mechanisms that exist

in this country, the New Zealand midwife is in a unique position in that she holds the contract of service with each and every woman she attends. The funding mechanism lends itself to and reinforces the philosophical position of midwifery as a partnership between the woman and the midwife. This, we believe, is the strength of the New Zealand maternity system. Maintaining these achievements for midwifery and for women through changes in future health policy direction and possible changes to this funding mechanism will require new strategies, including the establishment of mechanisms for collective midwifery action and the development of birth centres and primary maternity facilities as preferred locations for birth.

REFERENCES

Campbell N 2000 Core midwives–the challenge! 6th National Conference of New Zealand College of Midwives 2000 September 28–30, Cambridge New Zealand College of Midwives, Christchurch, p 187–193

Cunningham W, Dovey S 2000 The effect on medical practice of disciplinary complaints: potentially negative for patient care. The New Zealand Medical Journal 113 (1121): 464–467

Daellenbach R 1999 Midwifery partnership: a consumer's perspective. New Zealand College of Midwives Journal 21: 22–23

Donley J 1986 Save the midwife. New Woman's Press, Auckland

Gauld R 2001 Revolving doors: New Zealand's health reforms. Victoria University of Wellington, Wellington

Guilliland K, Pairman S 1995 The midwifery partnership: a model for practice. Victoria University of Wellington, Wellington

Guilliland K 1998 A demographic profile of independent (self employed) midwives in New Zealand Aotearoa. (Masters thesis) Victoria University of Wellington, Wellington

Health Funding Authority 2000 Maternity services: a reference document. Health Funding Authority, Government Printing Office, Wellington

Health Funding Authority 1999a Consumer perceptions of maternity care: results of the 1999 National Survey. Health Funding Authority, Government Printing Office, Wellington

Health Funding Authority 1999b New Zealand mothers and babies: an analysis of national maternity data. Health Funding Authority, Government Printing Office, Wellington

King A 2001 The primary healthcare strategy. Ministry of Health, Wellington

Midland Region Health Funding Authority 1998 Pregnancy and childbirth in the Midland Region. Health Funding Authority Midland Office, Hamilton

Ministry of Health 1999 Obstetric procedures 1988/89–1997/98. Ministry of Health, Wellington

Ministry of Health 2001 Report on Maternity 1999. Ministry of Health, Wellington

Ministry of Health 2002 Maternity services notice pursuant to Section 88 of the New Zealand Public Health and Disability Act, Ministry of Health, Wellington

National Health Committee 1999 Review of maternity services in New Zealand. National Health Committee, Wellington

New Zealand College of Midwives 2002 Midwives handbook for practice. New Zealand College of Midwives, Christchurch

New Zealand Government 1998 Accident Insurance Act. New Zealand Government Printer, Wellington

New Zealand Health Information Services 2002 New Zealand workforce statistics 2001: nurses and midwives. Available at: *http://www.nzhis.govt.nz/stats/nurses.html*

Nursing Council of New Zealand 1999 Guidelines for competence-based practising certificates for registered midwives. Nursing Council of New Zealand, Wellington

Otago Polytechnic 1999 Bachelor of Midwifery curriculum document. Otago Polytechnic, Dunedin

Pairman S 1998 The midwifery partnership: an exploration of the midwife/woman relationship. (Masters thesis) Victoria University of Wellington, Wellington

Pairman S 1999 Partnership revisited: towards midwifery theory. New Zealand College of Midwives Journal 21: 6–12

Ramsden I 1990 Kawa Whakaruruhau: cultural safety in nursing education in Aotearoa. Ministry of Education, Wellington

Skinner J 1999 Midwifery partnership: individualism, contracturalism or feminist praxis? New Zealand College of Midwives Journal 21: 14–17

Tracy M, Guilliland K, Tracy M (in press)

Tully E, Daellenbach R, Guilliland K 1998 Feminism, partnership and midwifery. In: Du Plessis R, Alice L (eds) Feminist thought in Aotearoa New Zealand. Oxford University Press, Auckland, p 245–253

Part Four: Midwifery Education

Part Four: Midwifery Education

Part Four of this thesis explores New Zealand midwifery's third key professionalising strategy, education for midwifery autonomy. I begin by providing a descriptive historical overview of key changes to midwifery education from 1979 to 2005 that demonstrates how midwifery education is linked with midwifery professionalisation in the shift from workforce to profession. This overview is primarily descriptive rather than analytical because it is important, in the first instance, to record these events. This is not to say that this is without analysis and critique, but rather its primary purpose is to record, as there has been no comprehensive recording of developments in New Zealand midwifery since Joan Donley's (1986) book 'Save the Midwife'.

As mentioned in the portfolios to Parts Two and Three, Karen Guilliland and I are currently writing a book that aims to follow on from Joan's book by recording and describing developments in midwifery since 1986 and up to the present. As part of that work I will record changes in midwifery's system of education since 1986 and the following historical overview begins that work. This overview, like the other chapters written by Karen and me for our planned book, is still a work in progress. The importance of including it here is to locate my discussion of three themes that emerge from this examination of midwifery education in New Zealand since 1979. These are: promoting autonomy, partnership, and women-centred care; promoting collaboration; and enhancing professionalism.

It is necessary to examine changes to midwifery education from 1979 to 2005 in order to provide a context to the discussion of the themes identified above. As I have already shown, a key aspect of midwifery's professional project was to define midwifery as a profession in its own right, most particularly as separate to nursing. Midwifery had become subsumed into nursing throughout the 1900s and finally in the 1971 Nurses Act the word 'midwife' had been removed from the title of the legislation and midwifery practice was defined as 'obstetric nursing'. The profession of nursing considered midwifery to be a specialty area of nursing practice, and therefore considered midwifery education to be appropriately an advanced nursing course. Midwives on the other hand, considered

midwifery to be a separate discipline, a profession in its own right, therefore requiring separate education programmes; midwifery programmes not nursing programmes.

The definition of a midwife as a 'nurse', a specialty of nursing, such as in the New Zealand Nurses Association definition (NZNA,1981), was the focus of dispute between midwifery and nursing from 1971 until midwifery separated from NZNA and formed the New Zealand College of Midwives in 1989. Alongside, and intertwined with this argument, was the issue of midwifery education. If midwifery was a separate profession then it needed separate education programmes. As will be identified in the following historical overview, the transition of midwifery education from a 'special topic' within the Advanced Diploma of Nursing to a three-year direct entry Bachelor of Midwifery programme, reflects the transition of midwifery from workforce to profession, and indeed, as will be discussed later, these changes in midwifery education were a deliberate professionalisation strategy on the part of midwifery.

Midwifery education, like the midwifery profession, has evolved and changed in response to midwives' growing understandings of professionalism, in response also to women's expectations, to changes in the socio-political context, to research and new knowledge, and to pedagogical understandings of learning and teaching. At the same time midwifery education itself has influenced and shaped some of these factors and the process of education needs to be seen as a reciprocal and shifting process in relation to midwifery professionalism and professionalisation and in a particular socio-political context.

The central purpose of midwifery education is to prepare midwives for practice, first as they enter the profession and then as they gain more experience and extend their practice. For New Zealand midwifery education, therefore, the focus is always on promoting autonomy, partnership, and women-centred care. This constitutes the first theme to be explored that results from the laying out of New Zealand midwifery's historical development. I will examine how this focus is expressed through midwifery curriculum development and some of the learning and teaching strategies that have evolved.

The second theme from this examination is collaboration. As a small country and a very small midwifery profession, midwifery has deliberately worked to promote collaboration in all our professionalising activities. In midwifery education this collaboration brings together educators, students, women (consumers) and the profession to ensure that midwifery education does not become separated from women and midwives or from practice. Collaboration in midwifery happens through a number of mechanisms and I will briefly discuss some of the significant collaborative events that have shaped midwifery education.

The third theme I have identified is 'enhancing professionalism'. This discussion focuses on developments in postgraduate midwifery education and continuing education and how these have enhanced midwives' professionalism.

Following discussion of these three themes I will return to consideration of midwifery education as a professionalising strategy and address questions such as why is it a strategy and how does it work as a strategy? I will then highlight some challenges to the future of midwifery education, in particular the impact of the government's tertiary education strategy and its funding processes (Tertiary Education Commission, 2002).

Finally I introduce the four portfolio pieces that further explicate the history of midwifery education in New Zealand and the themes that are discussed in Part Four.

Education for autonomy

Historical overview of midwifery education from 1979 to 2005

The 1904 Midwives Act established formal midwifery education in New Zealand through the St Helen's maternity hospitals, and this hospital based and apprentice-type model of midwifery education was available in New Zealand until 1979. Two routes to midwifery registration were available; an 18 month course for non-nurses (direct entry) that consisted of 12 months maternity training, ie. doctor-assistant, followed by six months of midwifery to prepare for independent practice; and a six-month midwifery course for registered nurses. In the intervening years changes were made to the content of this midwifery training but the two routes to midwifery registration remained.

The curriculum for midwifery training in the St Helen's hospitals was under the control of the Nurses and Midwives Board and changes were made to reflect changes in maternity services. By the 1960s the curriculum followed the obstetric divisions within hospitals and there were four periods of study – antenatal, labour, puerperium and paediatrics (Hill, 1982). Midwifery students were required to rotate through antenatal clinics and wards, labour ward, postnatal wards, the newborn nursery and the premature baby nursery (ibid). The six-month programme focused on the acquisition of skills and by the end of the 1960s concerns were beginning to be expressed about the adequacy of the theoretical content in the six-month programme (Hill, 1982).

By 1970 the St Helen's midwifery programmes had been reduced from seven to three to make way for more maternity nursing courses, which was the preferred model of both nursing and medicine. Concern about the standard of midwifery education was expressed throughout the 1970s with repeated calls from midwives to extend the programme from six months to one year. However, the 1971 Carpenter Report overtook any progress in this area.

The Carpenter Report 1971

In 1970 Dr Helen Carpenter, Director of the School of Nursing, University of Toronto, Canada and World Health Organisation consultant, was brought to New Zealand by the government to advise on nursing education. Her report provided a catalyst for major change in the way that nursing education was understood and delivered. It culminated in a shift from hospital based apprentice-style training to a polytechnic-based student focused education system (Papps, 1997). It also shifted the prescriptive curricula to more liberal and theoretical nursing education that prepared the 'comprehensive nurse' who was able to provide care in a variety of health care settings.

Carpenter saw midwifery as post-basic nursing and argued that this course would be improved by shifting it into the tertiary system (Donley, 1986). In response to the Carpenter Report the newly established Midwives and Obstetrical Nurses Special Interest Section of the New Zealand Nurses Association (NZNA)[iii], known as the Midwives Section, presented remits at the 1971 and 1973 NZNA Annual Conferences, calling for the St Helen's midwifery courses to be improved by extending them from six to twelve months (Hill, 1982; Donley, 1986). The Nurses and Midwives Board (shortly afterwards replaced by the Nursing Council) resolved not to extend the course while the general review of nursing education was in progress (Hill, 1982).

The Midwives Section made further attempts in 1974 but these were unsuccessful. In 1975 NZNA, with assistance from the Midwives Section, presented a proposal for a one-year midwifery programme to the Nursing Council. This programme was designed in response to the Carpenter Report in that it was capable of translation into the tertiary education system rather than necessarily being delivered as a hospital-based programme (Donley, 1987). In 1976 the Nursing Council forwarded the draft one-year midwifery programme to the Minister of Health (Nursing Council of New Zealand, 1978; Hill, 1982). This move was supported by the government's own 1976 Report on Maternity Services in New Zealand, which identified the need for an extended programme to prepare midwives for the more extensive role they were experiencing in rural hospitals, where they worked in isolation (Hill 1982).

However, these moves for a one-year hospital-based midwifery programme were unsuccessful and the government adopted the recommendations of the Carpenter Report. The government's priority was to shift nursing education from hospitals to the tertiary education sector and midwifery was swept along in this. Post-basic nursing courses were established in tertiary education institutions in four main centres. Named the Advanced Diploma in Nursing (A.D.N) each course ran over one academic year and comprised a core advanced nursing module plus one optional module from a choice of four. These were maternal and child health, community health nursing, medical / surgical nursing and psychiatric nursing. Midwifery was a 'sub option' within the maternal and child health option. Much to the disappointment of many midwives, the St Helen's midwifery programmes were closed with the last class graduating in 1979 (Hill, 1982).

Advanced Diploma of Nursing Midwifery Option

With the closure of the St Helen's midwifery programmes the only route to midwifery registration was through the Advanced Diploma of Nursing (A.D.N) programmes offered in four polytechnics; Auckland Institute of Technology (AIT), Waikato Polytechnic, Wellington Polytechnic and Christchurch Polytechnic. Because the A.D.N programmes were post-registration courses, only nurses with at least two years post-registration experience were eligible to enrol (NZNA, 1984).

The midwifery option had several internal inconsistencies. One was that before entry nurses had to undertake one year of practical experience in a maternity hospital. Strangely this prerequisite was counted towards the clinical practice component of the A.D.N midwifery option, even though it was prior to any midwifery theory. Any notion of integration of theory and practice was therefore unworkable. This requirement also demonstrated confusion about the differences between midwifery and obstetric nursing. The other main difference between the midwifery component and other A.D.N options was that nurses were required to meet both the academic requirements for the maternal and infant health option and the midwifery registration requirements of the Nursing Council of New Zealand. These included passing the State Final Examination for midwifery. Therefore midwifery

students had to undertake twice the workload of other A.D.N students, and within the same timeframe. They were also required to work at two levels of learning: as a new practitioner in midwifery and as an advanced practitioner in nursing (NZNA, 1987a).

The midwifery component itself was considered unsatisfactory as it provided for only 10 - 12 weeks of clinical experience and limited theory (Nursing Council of New Zealand, 1985). Graduates required significant support for long periods of time as they made the transition to registered midwife (NZNA, 1987a). Nurses, too, saw the programme as unsatisfactory and from the closure of the St Helen's programme the number of midwives registering from the A.D.N/Midwifery programmes decreased dramatically from previous numbers (see Table One below). Some nurses travelled to Australia and Great Britain to undertake their midwifery training but the numbers returning to New Zealand remained between 39 and 56 from 1983 to 1986, and these numbers did not bring midwifery registrants from New Zealand up to their previous levels (Donley, 1986; NZNA, 1987a).

Table One. New Zealand midwives registering from NZ midwifery programmes 1976 – 1987

Hospital Board	1976	1977	1978	1979	1980
Programmes (St Helen's Hospitals)	162	157	185	163	120*

Technical Institute	1981	1982	1983	1984	1985	1986	1987
Programmes	18	13	24	23	27	29	33
NZ nurses trained overseas as midwives			1983	1984	1985	1986	
			39	56	39	39	

*Concurrent hospital and technical Institute course graduates. Source: NZNA, 1987a, p.5

Midwives were also concerned that registered direct-entry trained midwives were excluded from the A.D.N maternal and child health option on the basis that they were not nurses. If midwifery was indeed a post-basic nursing course then it is difficult to see why these

midwives should be excluded from developing their knowledge and skills through the A.D.N maternal and infant health module. Therefore this group of midwives had no opportunities for post-registration midwifery education (Midwives Section, 1986). Similarly those midwives who gained midwifery registration through the A.D.N programme were not permitted to return to complete the maternal and infant health option in order to advance their practice. Nurses who had completed one of the other A.D.N options also could not return at a later date to undertake midwifery registration (NZNA, 1987a; Midwives Section, 1987a).

The decision to incorporate midwifery training into the A.D.N (Maternal and Child health option) was the subject of debate from 1978 onwards. The Midwives Section was vocal in its opposition. First it lobbied against its establishment, and then when that was unsuccessful, they lobbied for its discontinuation.

The Midwives Section used the democratic processes of NZNA to try and bring these programmes to an end. However, it was a slow and cumbersome process.

> *In three separate conferences, in 1980, 1982 and 1985, members have resolved that the Minster of Education be requested to make provision for a separate midwifery course leading to registration to replace midwifery registration as an option in the Advanced Diploma programme in technical institutes, thus leaving the Advanced Diploma course for registered midwives wishing to further their education* (NZNA, 1987a, p.3).

However, midwifery political activity continued on other fronts. The Midwives Section, midwifery students, midwifery teachers, and midwife-employers all expressed concerns about the A.D.N/midwifery option (Kennedy & Taylor, 1987; Midwives Section, 1987a). Many midwives wrote to the Ministers of Health and Education asking for midwifery education to be separated from the A.D.N programmes (Midwives Section, 1987b). Some midwives approached the polytechnics directly requesting separate courses and as a result in 1986 Otago Polytechnic and Southland Community College applied to the Department of Education for funding to provide a separate midwifery programme. This was planned to

be a regional midwifery diploma programme and by 1987 the two polytechnics had begun to prepare a curriculum. Funding was not forthcoming for that venture but the Department of Education did begin to respond to some of the concerns midwives were raising (Midwives Section 1987b).

The Department of Education undertook an initial evaluation of the courses in 1980 and found they were operating well (Kennedy & Taylor, 1987). This is unsurprising as at this very early stage it would have been difficult to make an informed decision about the outcomes. However, a more substantial evaluation undertaken in 1983 and finally completed in 1987, identified a number of issues (Kennedy & Taylor, 1987; NZNA, 1987a). These included: dissatisfaction of students; the workload required to complete two programmes concurrently; the limitations of the theory and practice components; and the perception of employers that graduates were inadequately prepared for midwifery practice (Kennedy & Taylor, 1987; NZNA, 1987a).

The Department of Education report of 1987 made no specific recommendations for midwifery education, but the NZNA submission on the report recommended modification of the midwifery component of the ADN in order to address the identified concerns. NZNA suggested that this could be done through a pilot programme (NZNA, 1987a). Midwives were concerned that NZNA did not reflect its (by now) policy of separate courses for nursing and midwifery in this submission (NZNA, 1987a).

As a result of submissions on the report the Department of Education agreed to run a residential workshop at a conference centre, called Lopdell House, in Auckland to facilitate the rewriting of the midwifery component of the A.D.N (Midwives Section, 1987b). This course was planned for December 1987 and the National Midwives Section representatives were to be Karen Guilliland, Maureen Leong (a midwifery tutor from Waikato) and me (Midwives Section, 1987b). In the event, this Lopdell House workshop was not run until 1988, when it provided an opportunity for midwifery educators in various polytechnics to plan the content of the proposed separate midwifery courses. I will return to this later. Firstly I will discuss how differences between the Midwives Section and NZNA over

midwifery education highlighted for midwives their lack of 'voice' within the New Zealand Nurses Association. This frustration led directly to the decision finally taken in 1988 by the Midwives Section, to establish the New Zealand College of Midwives.

Divergent views on midwifery education

It became clear to Midwives Section members that achieving a policy change at the NZNA conferences in 1980, 1982, and 1985 to support the proposal for midwifery to be separated from the A.D.N did not mean that the NZNA would action this policy. In fact NZNA wrote only one letter as a result of these remits, and then not until 1985. The Minister of Education responded to NZNA's letter requesting separate midwifery education programmes by saying that nothing would be done until the review of the A.D.N was completed and NZNA accepted this without challenge (Donley, 1987).

This relatively passive approach by NZNA was not surprising given that NZNA, in its 1984 policy on nursing education, considered that the Midwives Section's resolutions seeking the separation of midwifery training from the A.D.N programmes caused *"a problem as yet unresolved by NZNA"* that posed *"professional and educational difficulties"* (NZNA, 1984, p.33). The explanation given for these difficulties was twofold. First, midwifery knowledge and skills built on nursing knowledge and skills and were therefore post-basic nursing skills. Secondly the A.D.N was educationally designed to extend basic nursing skills and therefore, because midwifery involved advanced skills, it should be taught within the A.D.N (NZNA, 1984).

This 1984 policy on nursing education was developed by a working party of nurses chaired by Maureen Laws, a nurse and midwife, who at the time was the postnatal supervisor at Wellington Women's Hospital and the NZNA nominee to the Advisory Committee for the A.D.N evaluation (NZNA, 1984; Donley, 1987). Interestingly this policy statement was at odds with another statement released by the NZNA Midwives Section in 1984 titled, 'Report of the Working Party looking into Education for the Role, Scope and Sphere of

Practice of the Midwife in New Zealand' of which Maureen Laws was also a member (Midwives Section, 1984).

A Midwives Section National Seminar held in Auckland in May 1982 identified the need for a cohesive policy on midwifery issues, especially education, and a working party was established to prepare draft policy (Midwives Section, 1984). The working party consisted of regional representatives from the NZNA Midwives Section who were charged to,

> *Make recommendations to appropriate organisations on the educational preparation for the role, scope and sphere of practice of the midwife in New Zealand* (Midwives Section, 1984, p.2).

The 13-member working party met for one day in April 1983 and then circulated a draft report to the eight regional midwives sections for consideration. The final report and recommendations were adopted unanimously at the Midwives Section Annual General Meeting in April 1984. The report focused on problems with the Advanced Diploma of Nursing midwifery option and its primary recommendations were as follows:

- *That the midwifery course be retained within the technical institute system;*
- *That midwifery registration be retained;*
- *That the midwifery course be separated from the Advanced Diploma of Nursing and directed toward preparation of the beginning practitioner in midwifery;*
- *That provision continue to be made for the admission of registered midwives to the Advanced Diploma of Nursing Course in sufficient numbers to maintain the development of the midwifery service;*
- *That funding be provided for both courses;*
- *That the concept of clinical teaching contracts in approved clinical settings be investigated to ensure that the optimum clinical experience is offered to students;*
- *That discussion take place between the New Zealand Nurses Association, the Midwives Section, the Nursing Council, the Departments of Health and Education and the Technical Institutes to reconsider the length and structure of the course, and the need for a pre-requisite clinical year.*

- *That the New Zealand Nurses Association Policy Statement on Maternal and Infant Nursing (1981) be revised and updated in the light of current community needs and professional developments.* (Midwives Section, 1984, pp. 9-10).

The final recommendation referred to another policy that had shaped NZNA's views on midwifery and midwifery education. In February 1980 the National Executive of NZNA established an Ad Hoc committee to develop policy on nurses and nursing within the context of maternal and infant health (NZNA, 1981). The committee of six included Maureen Laws and Margaret McGowan, then National President of the Midwives Section. The resulting Policy Statement on Maternal and Infant Nursing set out in strong terms the NZNA's view that midwives were nurses, in fact the report used the term 'maternal and infant health nurse' interchangeably with 'midwife'. The report stated that;

> *The Association (NZNA) considers a midwife to be a nurse who by reason of her advanced educational preparation, knowledge and skills, is qualified to care for women during pregnancy, delivery and the postnatal period, and for the fetus and neonate. This care includes the active promotion of health and comfort by whatever means are most appropriate and the prevention of complications. The detection of problems either actual or potential for the mother, fetus or the neonate requires that the midwife obtains medical assistance, although she is qualified to carry out emergency measures in the absence of medical help. The midwife practises her profession in any setting where her skills are required. Her focus of practice is the health of the family and the individuals that comprise it* (NZNA, 1981, p.20).

The policy statement also affirmed the NZNA belief that,

> *Midwifery is a post-basic qualification in that the midwife utilises the nursing concepts learned during the basic nursing programme, and builds on these, at the same time acquiring new skills and knowledge relating to the practice of midwifery* (NZNA, 1981, p.9).

Domiciliary midwifery as a focus for control by nursing and obstetrics

In setting out its vision for maternal and infant health nursing through this policy statement NZNA expressed concern about domiciliary midwifery and home birth services. NZNA commented that increasing numbers of women were requesting home confinements and being attended by domiciliary midwives, *"albeit in conjunction with medical supervision of the client"* (NZNA, 1981, p.17). The policy statement expressed the concern that these domiciliary midwives might be *"ill-prepared"* and it proposed a set of minimum standards that should be applied as a pre-requisite for any midwife applying to the Department of Health for a contract for payment for domiciliary midwifery services (NZNA, 1981, p.17). These proposed standards included: two years continuous employment in a maternity hospital; limitation to a geographical area of practice within half an hour of a maternity facility; and assessment of the midwife's suitability and competence by the Principle Nurse and the Obstetrician in charge of the facility. NZNA also proposed that once a midwife was granted a contract to work as a domiciliary midwife, she should have to meet other requirements. These included: conducting at least 15 normal births annually; undertaking annual in-service education at a maternity hospital; participating in other educational programmes and having their practice formally evaluated annually by a competent midwife or an obstetrician. This evaluation would include examination of client records (NZNA, 1981). The policy further recommended that NZNA take action to ensure that these criteria were accepted by the Department of Health and implemented. This policy was not accepted by the Department of Health but aspects of it were reflected in the later 1983 Amendment to the Nurses Act, which I will discuss shortly.

The appendix to the 1981 policy on maternal and infant health nursing was written by the Midwives Section and set out its position on home confinement. The Midwives Section clearly stated that it did not support home birth, suggesting that a *"relatively small group of vociferous advocates of home confinement"* chose homebirth because they were concerned about the hospital setting for birth (Midwives Section, in NZNA, 1981, p.ii).The Midwives Section suggested as a solution that maternity hospitals be improved and made more 'homelike' and that women's requests and needs should be respected. Early discharge

schemes were proposed and even the concept of continuity of care was suggested where the same midwife would provide all care but the woman would birth in the hospital. The policy expressed the Midwives Section's view that women would not request home birth if they really understood what was involved. It stated,

> *In the absence of positive sanctions against those who condone and support the trend towards home confinement, the responsibility of the health services is quite clear. Equity of care demands that the health of neither the woman nor her baby be endangered because of her decision* (Midwives Section in NZNA, 1981, p.ii)

The Midwives Section suggested that this could be achieved if controls were placed over domiciliary midwives to restrict the *"relatively independent nature of this practice"* (Midwives Section in NZNA, 1981, p.18). As well as including this policy on home confinement as the appendix to the NZNA policy on maternal and infant health, the Midwives Section also submitted their policy to the government's Board of Health Maternity Services Committee in February 1980 (NZNA, 1981). By agreeing to have the policy statement included as an appendix in the substantive 1981 NZNA policy on maternal and infant nursing, it appears that the majority of Midwives Section members at that time also agreed that midwifery was a post-basic specialty of nursing.

Joan Donley, in her book 'Save the Midwife', records that this policy statement and the appended policy from the Midwives Section on home confinement, caused a major rift amongst midwives and heightened existing antagonism between hospital midwives and domiciliary midwives, to the point that seven domiciliary midwives, including Joan, formed the Domiciliary Midwives Society Incorporated (DMS). The purpose of the DMS was to represent the views of domiciliary midwives to government agencies and to oppose the recommendations of NZNA in relation to domiciliary midwifery (Donley, 1987).

Domiciliary midwives were 'relatively independent' in their practice because they did not have to be employed by hospitals. Fortuitously, when the St Helen's hospitals were transferred from the control of the Department of Health to Hospital Boards in 1969, the domiciliary midwife contracts were not transferred. This was probably an oversight because

there were so few domiciliary midwives in practice at that time. Although this meant that domiciliary midwives continued to be paid very low rates, they could claim this payment directly from the Health Department rather than being employed in hospitals. Therefore they were not subject to the same level of control as employed midwives from hospital protocols and hospital hierarchies. The ability of domiciliary midwives to claim payment from the Health Department meant that when the 1990 Nurses Amendment Act was passed there was an existing mechanism to enable midwives to claim payment from the Maternity Benefit Schedule. As discussed in Part Three, the right of midwives to claim payment from the government central primary health funding mechanism was essential to the subsequent development of an autonomous midwifery profession.

Domiciliary midwives played a key role the development of midwifery in New Zealand. Because of their relative autonomy outside of the hospitals they offered women a model of midwifery practice that was more in line with the International Confederation of Midwives' definition of a midwife (see note i), thus keeping alive an understanding amongst some women of what a midwife could be. As has been discussed this definition became somewhat of a mantra for midwives in subsequent years, because it not only defined a midwife as a 'person' rather than a 'nurse'; it also defined the midwifery scope of practice to which New Zealand midwifery aspired.

Throughout the 1980s domiciliary midwives were the midwives who came closest to this international definition. Although the 1971 Nurses Act (later replaced by the Nurses Act 1977) required them to work under the supervision of a doctor, domiciliary midwives still worked in the community and in women's homes providing continuity of care from pregnancy through to the postpartum period.

But women requesting homebirth and the few domiciliary midwives and doctors who supported them, were out of step with the majority of midwives, nurses and doctors and the direction that the maternity services were taking. One group with strong influence over the direction of maternity service development in New Zealand was the Maternity Services Committee, a standing committee of the government Board of Health, and made up largely

of obstetricians. In 1979 this committee released a policy statement titled 'Obstetrics and the Winds of Change" (Board of Health, Maternity Services Committee, 1979). It provided advice on how doctors and nurses could meet the demands of *"a vocal minority"* and asked, *"How can we protect the lives and IQs of our future citizens and counter this move away from our hospitals?"* (Board of Health, 1979, p.1). The policy statement recommended strategies to make hospitals more like homes, such as relaxing certain attitudes and protocols to provide more flexibility and individuality, so that women would want to have their babies in hospitals instead of at home (Board of Health, 1979).

This policy was followed in 1982 with another entitled, 'Mother and Baby at Home: the early days' that also opposed homebirth and prescribed a large number of so-called 'risk factors' that would require women to be referred to obstetricians for care (Board of Health, 1982). These risk factors were further tightened in 1983 to include all women having their first baby (Bonham, 1983). Professor Bonham, a leading obstetrician at that time, set these further criteria in his paper titled 'Whither Obstetrics', which also outlined a plan for regionalisation of the maternity services and promoted a number of obstetric interventions such as artificial rupture of the membranes upon admission in labour, episiotomy, forcep delivery, and routine use of oxytocic drugs to manage the third stage of labour (Bonham, 1983). These interventions became routine practice in the 1980s and ironically provided some impetus for consumer activism through the 1980s to resist this medical and interventionist approach to birth.

The 1982 Maternity Services Committee policy proposed to control domiciliary midwives by recommending that their contracts be transferred from the Department of Health to Hospital Boards and that their practice be reviewed by the hospital Obstetric Standards Review Committees (Board of Health, 1982). The Domiciliary Midwives Society (DMS) vigorously opposed this claiming that it was inappropriate for one profession to assess another, as their roles were different (Donley, 1986). The DMS was initially successful but domiciliary midwifery practice was constrained in legislation passed in 1983 by way of an amendment to the Nurses Act 1977, and again in 1986 through a review of the Obstetric Regulations.

By the time these legislative changes were proposed it was increasingly clear that the Midwives Section held different views to those of the parent body, NZNA. The Midwives Section believed that midwifery education was best provided in specific programmes separate to the A.D.N. NZNA believed that as a nursing specialty, midwifery belonged in the A.D.N programme. NZNA policy defined the midwife as a 'nurse' while the Midwives Section defined the midwife as a 'person' (NZNA, 1981; Donley, 1986; Midwives Section, 1986). The Midwives Section membership included approximately 200 practising midwives who were not general nurses and the definition of a midwife was an increasing point of tension between midwives, and between NZNA and the Midwives Section.

However, midwives also disagreed amongst themselves. Hospital-employed midwives and domiciliary midwives saw their role and scope of practice differently and disagreed about the safety of homebirth and domiciliary midwifery practice. These differences of opinion were to come to a head with the introduction of the Nurses Amendment Bill in September 1983.

1983 Amendment to the Nurses Act 1977 and 1986 Obstetric Regulations

The 1983 Bill introducing amendments to the Nurses Act 1977 not only impacted on domiciliary midwives, it also impacted on direct-entry midwives, many of whom worked in hospitals and were active in the Midwives Section. The Bill proposed that all domiciliary midwives must also be registered nurses, thus excluding direct entry midwives from home birth practice. The Bill proposed the removal of the restriction that only midwives could care for women in labour, opening the way for nurses without midwifery registration to provide this care. Finally it proposed an increase in the powers of the Medical Officer of Health to suspend domiciliary midwives on suspicion of 'unhygienic' practice (Donley, 1986).

The Midwives Section prepared a submission to the government Select Committee pointing out that midwifery practice was different from obstetric nursing, and seeking protection for the right of direct entry midwives to practise in home birth settings (Donley, 1986). The Section came into serious conflict with NZNA over the submission and NZNA would not allow it to be submitted because it was at variance with the NZNA submission and because NZNA's constitution prevented Sections from speaking publicly (Papps & Olssen, 1997).

Fortunately a group of homebirth women formed a consumer group called 'Save the Midwives Society' to lobby against the 1983 Amendment Bill, and their protests resulted in some changes to the final Act. These included a 'grandfather' clause allowing those direct entry midwives already working as domiciliary midwives to continue to do so; continued rights to registration in New Zealand for overseas trained direct entry midwives; and the Medical Officer of Health had to have at least 'reasonable' suspicion of unhygienic practices to suspend a domiciliary midwife from practice (Donley, 1986).

Nevertheless the 1983 Nurses Amendment Act strengthened the control by medicine and nursing over midwifery. The eagerness of medicine and nursing to bring domiciliary midwifery into line was further emphasised in the 1986 rewrite of the Obstetric Regulations. This much shorter document related almost entirely to domiciliary midwives and removed virtually all its previous references to requirements for hospitals and doctors in relation to maternity services. Under the revised regulations it was no longer a requirement to have a midwife on duty at all times in maternity units (NZ Government, 1986). Extensive requirements were set out for domiciliary midwives in relation to documentation and maintenance of client registers, but almost none for maternity facilities. The explanatory note said,

> *Many of the matters covered by those (1975) regulations are now dealt with in legislation or are now considered best left to good professional practice or administrative instructions* (NZ Government, 1986, p.6).

It appears that only domiciliary midwives were not considered capable of exercising good judgement without legislative requirements.

Midwives uniting

An unexpected consequence of these changes to legislation in 1983 and 1986 was that they united hospital and domiciliary midwives in a common cause to protect their midwifery identity. Midwives put aside their differences and became much more politically active. The Midwives Section worked hard to bring together the views of all its members across the country. It strengthened the regional committees and the chairpersons of each region formed the National Section, which met regularly to develop representative views on issues and strategies.

Through establishing its own working party in 1984 to review midwifery education, the Midwives Section challenged NZNA's perspective on midwifery education and persuaded it to review its 1981 Policy Statement on Maternal and Infant Nursing. NZNA set up an Ad Hoc committee in March 1986 to prepare new policy (NZNA, 1989). The membership of five included three representatives from the Midwives Section. The resulting Midwifery Policy Statement was developed through extensive consultation with midwives and women. This midwifery policy strongly supported midwifery autonomy and direct entry midwifery education (NZNA, 1989). However, by the time it was adopted as policy the Midwives Section had already separated from NZNA and formed a separate professional organisation, the New Zealand College of Midwives.

However, prior to the formation of the College, the Midwives Section succeeded in using NZNA's democratic processes to develop more midwifery-friendly policy. For example, in 1985 the Midwives Section succeeded in having NZNA accept the international midwifery definition of a midwife. A midwife was no longer required to also be a nurse. At the NZNA conference in 1986 the Section began its work to amend the Nurses Act when it moved that,

> *The NZNA treat as urgent the need to change Section 54(2) (a) of the Nurses Act 1977, as amended by the Nurses amendment Act, 1983, Section 17, so that nurses who direct and supervise obstetric care are also registered midwives* (NZNA, 1987b, p.33)

Again in 1988, a remit was passed requiring that NZNA,

Request the Minister of Health to amend Section 54 (1) of the Nurses Act 1977 (amended by the Nurses Amendment Act 1983 Section 17 (1)) to enable midwives to be autonomous practitioners in normal birth. (NZNA, 1988, p.44).

These remits added to growing recognition within NZNA and elsewhere that the Nurses Act needed to be amended to reinstate midwifery autonomy. As was mentioned in Part Two and Part Three of this thesis, the reinstatement of midwifery autonomy was the focus of combined political activity by maternity consumer groups and the Midwives Section from the mid-1980s onwards.

But perhaps the most significant event, apart from the growing unity amongst midwives, came during the 1987 NZNA conference. Here it was announced that there was to be a meeting on 29 September 1987 in the office of the Chief Nurse, to discuss options for midwifery education. The repeated submissions from midwives and others that midwifery education needed to change had finally borne fruit. Karen Guilliland and I represented the Midwives Section at that conference and, against strong opposition from the NZNA Executive Director, we insisted on the Midwives Section being represented at the meeting. At the Annual General Meeting of the Midwives Section on 23 September 1987, Karen and I were nominated to attend the meeting on behalf of the Midwives Section (Midwives Section 1987b).

Working party on Midwifery, Bridging and Related Courses

Karen and I attended the meeting on 29 September 1987. The Department of Health was represented as well as NZNA and two polytechnics. The Chief Nurse presented four options for midwifery education: direct entry, separate course, status quo (A.D.N) or a dual system of A.D.N Midwifery and separate midwifery courses. The options were discussed and, not surprisingly, we were the only two in favour of direct entry midwifery education and we also supported the separate courses. The nurses seemed generally in favour of the status quo or dual options. The Chief Nurse informed the meeting that new funding for

separate courses would not be available and would have to be found elsewhere, such as through phasing out of other types of nursing education.

A follow-up meeting was held in October 1987 where we were informed that the Minister of Health's decision was imminent. Although we were not told what the Minister's decision would be, the fact that we were asked to consider how to implement the dual option made it fairly clear (Department of Health, 1987). The meeting discussed a proposal to obtain funding by phasing out nursing 'bridging' programmes and phasing in midwifery courses and short courses for nurses in specialty areas of nursing practice (Department of Health, 1987). The Working Party on Midwifery, Bridging and Related Courses was established by the Department of Health and both Karen and I were appointed as members.

On 7 December 1987 the Ministers of Health and Education and the Acting Minister of Women's Affairs issued a joint press release announcing that a *"dual training option"* would be introduced in 1989 (Ministers of Health, Education and Women's Affairs, 1987). Midwifery education would be available separately to the Advanced Diploma in Nursing, although the A.D.N Midwifery Option would continue to be available in a limited number of places. It would also remain available for midwives seeking further qualifications. In addition bridging courses that had been available for registered psychiatric and psychopaedic nurses to obtain comprehensive nursing registration would be phased out. Short courses would be available for the specialist training needs of nurses (ibid).

Midwives were pleased with the decision for dual education programmes although it had been a compromise. The Working Party on Midwifery, Bridging and Related Courses (Working Party) first met in February 1988 and over a series of four meetings until July 1988 the working party planned the implementation of dual option policy. There were 14 members on the working party and Karen and I were the only midwives. The minutes of the meetings and my notes at the time record some dissent and antagonism towards midwifery in relation to the perception of some nurses that bridging course for psychiatric and psychopaedic nurses were closing because of midwifery. There was also dissent in relation to attempts by some nurses to dictate the philosophy and content of the separate midwifery

programmes (Reid, D, Personal Communication from Karen Guilliland, March 3, 1988; Working Party 1988).

These issues notwithstanding, the Working Party developed a plan for the phasing in of one-year separate midwifery programmes and nursing short courses. This involved reallocating funding between the seven polytechnics that had previously provided A.D.N programmes and Bridging programmes. Bridging programmes were phased out over three years and student places from the A.D.N and Bridging programmes were redistributed enabling funding for the one-year separate midwifery programmes and for short courses. The Working Party consulted with hospitals, polytechnics and the wider profession in this planning and eventually recommended that separate midwifery courses would be established from 1989 at the Auckland Institute of Technology (AIT), Wellington Polytechnic and Otago/Southland Polytechnics. The A.D.N Midwifery Option would continue at Waikato Polytechnic and Christchurch Polytechnic. An evaluation would be carried out over three years until 1991, by which time all Bridging courses would have been phased out.

The evaluation was to be of each year of each course and would involve questionnaires to students, midwifery practitioners, educators and employers. The Department of Education was to conduct the evaluation and, at the end of three years, this evaluation would be the basis for the future direction of midwifery education. If separate courses were shown to have better outcomes than the A.D.N Midwifery Option, then Waikato and Christchurch Polytechnics would be approved to also provide separate courses (Working Party, 1998).

Because of the way funding was allocated the new one-year separate midwifery courses were established within Schools of Nursing that had previously offered midwifery training through the A.D.N/Midwifery option. Otago Polytechnic, working in association with Southland Polytechnic, was the exception to this. Southland Polytechnic had offered bridging courses since 1985. Geographically it was thought they should be at Otago to meet the greater population need. However, the Nursing Department at Otago Polytechnic was only established in 1984 and was not yet ready to offer these courses. It had been difficult

for Southland to fill its allocated places and it was decided to transfer these resources from Southland to Otago as part of the phasing out of Bridging programmes and establishment of short courses (Department of Health, 1988a). Additionally, Otago and Southland Polytechnics had previously made a joint submission to the Departments of Health and Education in 1987 suggesting they be approved to offer a joint midwifery programme separate to the A.D.N. Thus the initial approval for the one-year midwifery programme at Otago was as a joint venture between Otago and Southland polytechnics (Department of Health, 1988a). This combined programme was known as the Southern Region Midwifery Course. The joint arrangement was to continue until 1991 when the cessation of the Department of Education evaluation process allowed the two Polytechnics to go their separate ways in regard to midwifery.

Lopdell House Workshop

To assist the polytechnics to prepare for these new separate midwifery programmes and to further develop the evaluation process, the Departments of Health and Education organised a five-day residential course at Lopdell House in Auckland in July 1988. Course participants included one midwifery educator from each polytechnic that would be offering midwifery (AIT, Waikato, Wellington, Christchurch, Otago, and Southland), one midwife practitioner, one midwife employer, and representatives from the Departments of Education and Health. Jan Grant, a Nurse Advisor from the Department of Education, coordinated the course. The Midwives Section nominated Auckland domiciliary midwife Joan Donley as the midwife-practitioner. Initially the Department of Health refused Joan's nomination because they understood she was *"only a direct entry midwife"* but they were forced to accept her when her registration as a general and obstetric nurse as well as midwife was made known (Midwives Section, 1988b). The Departments of Health and Education refused the Midwives Section request that maternity consumers be represented (ibid). I attended this course to represent Otago Polytechnic.

The main objectives of the course were to establish a framework for the curricula of the one-year midwifery programmes and to develop an evaluation process for both types of

midwifery programmes. The course was useful to the participants and the Midwives Section Philosophy and Standards for Midwifery Practice, Service and Education were adopted to guide curriculum development (Midwives Section, 1988b).

As a result of the Lopdell House workshop the Department of Health developed guidelines for establishing separate midwifery for registration courses, and released these in October 1988 (Department of Health, 1988b). Polytechnics were recommended to collaborate with service areas in curriculum development and to involve consumers and Maori in the process. The evaluation process was set out and questionnaires for this were enclosed (Health Department, 1988b).

Once developed the midwifery curricula required the approval of the Nursing Council of New Zealand, and in December the Council produced further information about their specific requirements for the courses (Nursing Council, 1988). The Council pointed out that there were minimum criteria for midwifery registration programmes already set in the Nurses Regulations 1986 and that the guidelines produced by the Department of Health exceeded these. For example, the minimum requirements of the Council were for minimum course hours of 1000 with at least 35% of these as theory and 50% as clinical. The Department of Health guidelines recommended that the minimum total hours would be 1100, with at least 45% as theory and 50% as clinical (Nursing Council, 1988). The Nursing Council also required that curricula would meet its Standards for Registration of Midwives, which included course content, clinical experience and expected midwifery skills (Nursing Council 1988). The three Diploma programmes that were submitted from AIT, Wellington Polytechnic and Otago/Southland polytechnics each met the Department of Health guidelines as well as the Nursing Council standards. .

The three one-year midwifery programmes and the two revamped A.D.N/Midwifery Options at Waikato and Christchurch polytechnics commenced in 1989. I will discuss in detail the establishment and development of the programme at Otago Polytechnic as an example of the separate programmes.

The Diploma of Midwifery at Otago Polytechnic

Otago Polytechnic received official notice from the Department of Education that it was approved to offer the separate midwifery programme on 5 September 1988. Ten student places were allocated for 1989, increasing to 15 in 1990 and 25 in 1991. Staffing increases were approved and the Polytechnic was permitted to appoint new staff from 1989, to a maximum of 3.75 tutors for midwifery by 1991 (Department of Education, personal correspondence September 5, 1988).

There were two midwives on staff in the Nursing Department at Otago Polytechnic in 1988, Christine Smith and myself. We were joined by Chris Hannah, a midwife from Wellington, and the team was completed by Moira Tebble, a midwife on staff at Southland Polytechnic. Together we developed the curriculum for the new Southern Region Midwifery Programme. At the same time we continued our teaching roles in the comprehensive nursing programmes.

Reading the curriculum document now, some 16 years later, it seems a very 'thin' document (Otago Polytechnic, 1989). However, despite the lack of pedagogical theory and minimal description of theoretical content or assessment processes, it was still an important document for its time. It stated,

> *This course has been developed around the woman, as the most powerful pivot of the childbirth experience and aims to produce a midwife at the beginning practitioner level. This midwife recognises birth as more than an isolated biological episode and understands that women who give birth have a past and a future* (Otago Polytechnic, 1988, p.4).

The curriculum was based on the Midwives Section Standards for Midwifery Practice, Service and Education and the NZNA Midwifery Policy Statement (Otago Polytechnic, 1988; Midwives Section 1988; NZNA, 1989). It was organised around three broad themes: the woman, the midwife and the process of normal childbirth, providing a framework for midwifery practice in which the woman and the midwife were understood to share an "*interdependent and equal relationship*" during the shared experience of childbirth (Otago

Polytechnic, 1988, p.15). The notion of 'partnership' between the midwife and the woman was not articulated, although reference was made to three principles in the Treaty of Waitangi of partnership, protection and participation. Beginning understanding of the notion of 'informed choice and consent' was articulated in the curriculum as,

> *Midwifery accepts the rights, needs and beliefs of people in maintaining their integrity as self-determining individuals. Clients must be involved in their own healthcare and be able to voice their needs, choices, alternatives, desires and rights* (Otago Polytechnic, 1988, p.6).

Women were identified as sharing in the teaching of students and contributing to their learning (Otago Polytechnic, 1988).

The course ran over 38 weeks from May to March to make better use of clinical teaching opportunities outside of the academic year when midwifery students would not have to compete with medical and nursing students for experience. Midwifery clinical experience was gained in Otago and Southland and each student spent six weeks working in two rural maternity units, fourteen weeks in the secondary/tertiary units in Dunedin and Invercargill, and two weeks on elective placements throughout New Zealand. Each student was expected to attend at least one homebirth (ibid).

The Nursing Council approved the curriculum in April 1989 and the first group of eleven students were selected from a shortlist of 19 (Nursing Council, 1989; Pairman, 1989). Fifty two nurses returned the preliminary application form but only 23 were able to complete the full application, the rest citing difficulties with funding and inability to travel as reasons why they could not apply at that time. Of the first group, 10 received student bursaries and one was fully self-funded. Five were from Southland and six from Otago (Pairman, 1989). The first graduation ceremony was held in Invercargill with subsequent graduations being held in Dunedin.

In 1990-1991 fifteen students were accepted and completed the course and in 1991-1992 a further sixteen students did the same. By 1991 the numbers of students applying from Southland were very low and the Department of Health evaluation of the midwifery

programmes had dissipated without a final conclusion. The 1990 Education Act gave more autonomy to polytechnics to decide which courses they would offer and funding for health courses began to be transferred from the Department of Health to the Department of Education, thus ending the capped student numbers approach in favour of funding on the basis of full-time equivalent student enrolments. Otago and Southland polytechnics agreed to end their joint venture relationship because student numbers were too few in Southland to make the process of offering the course in both places worthwhile (Dixon, A. personal correspondence, 1991; McMillan, personal correspondence, 1991). Although this formal relationship ended Otago has continued to offer 'one off' programmes in Southland approximately every ten years when there have been sufficient students to make this viable. These programmes have been run in collaboration with Southland District Health Board.

In 1992 the last Diploma in Midwifery course was run at Otago Polytechnic specifically for a cohort of registered nurses who had worked for many years in the local maternity hospital, Queen Mary. Queen Mary Hospital was moving to a policy of employing only registered midwives and these employees chose to complete the midwifery programme rather than move out of working in maternity and into nursing. The course was provided on a part-time basis (18 hours per week) from January 1992 until March 1993, and 16 nurses completed the programme while still maintaining part-time employment at Queen Mary (Pairman, S. personal communication to M. Roberts September 11, 1991).

By the time this course was run, the midwifery profession's expectations of midwifery education was changing rapidly to reflect the new models of independent (continuity and caseloading) midwifery that were developing. This group of students from Queen Mary hospital were required to carry a caseload of 6 – 8 clients for whom they provided continuity of midwifery care from early pregnancy through until six weeks postpartum. These 'follow-through' women were accessed through the Otago Polytechnic Independent Midwifery Service (IMS) and the midwives of the IMS provided supervision of the students. I will discuss the IMS later.

This last diploma course was also run concurrently with the Bachelor of Midwifery programme that commenced at Otago Polytechnic in 1992. Sally McNeill was appointed to coordinate and teach this last diploma course and she then joined the midwifery teaching team in the Bachelor of Midwifery. Upon graduation these nurses continued their employment in Queen Mary, but now as Registered Midwives rather than obstetric nurses.

Philosophical issues

While the philosophical approach to midwifery education expressed in the 1988 Southern Region Midwifery Curriculum is not surprising by today's standards, it was quite an unusual approach at that time (Otago Polytechnic, 1988). But to some extent the philosophy was not embedded in the teaching team or the wider nursing department. Whilst we consulted on the document as it was developed and received useful feedback from midwives and nurses that was incorporated into the final curriculum, we did not think to send the draft curriculum out for consultation amongst women's groups. At that stage in our development our focus was on trying to make the woman and her family visible for midwifery students, thereby influencing a more woman-centred focus for the maternity services. However, we did not actively work with women in this objective until our development of the direct entry midwifery curriculum in 1991.

For me personally, working as a domiciliary midwife as part of a collective with other midwives from 1988 and then establishing the Otago Polytechnic Independent Midwifery Service from 1991, were significant factors in my understanding of how childbearing women could be partners with educators and midwives in midwifery education. For the midwifery teaching team generally, the release in August 1988 of Judge Cartwright's Report of the Cervical Cancer Inquiry at National Women's Hospital in Auckland had a significant impact on how we began to think about women's rights in relation to their maternity care and in relation to students (Ministry of Women's Affairs, 1989). Our attempts to gain informed consent from women for midwifery student involvement in their care led us into conflict with doctors in Southland in 1989.

Towards the end of 1988, lecturer Moira Tebble, spoke to a meeting of general practitioners in Invercargill to inform them about the midwifery course that was planned to commence in 1989. She explained that we intended to seek informed consent from women for midwifery student involvement in their care and she sought their support for this and for teaching the students. This was followed immediately with a letter from the Southland Division of the New Zealand Medical Association to the polytechnics applauding the introduction of the course but stating that,

- *Private patients have selected us, as their Medical Practitioner, and we take ultimate responsibility for their total care. We will not give up this responsibility.*
- *The organisers of the Midwife Course cannot presume to have access to the private patients for teaching purposes.*
- *As we have final responsibility, we reserve the right to overall clinical management* (Vercoe, J. personal communication, December 15, 1988).

The doctors then sent a delegation to the Southland Area Health Board arguing that their contract with the Board was for use of the facilities only and that they had no obligation to allow midwifery students to access their patients (personal notes, 1989). When the draft curriculum document was distributed for consultation the doctors sought a legal opinion about it. The legal response advised that the course would place doctors at risk because it interpreted the course as preparing 'independent' midwives. This interpretation seemed to arise because of the inclusion of the International Confederation of Midwives definition of a midwife in the document, stating that a midwife is able to *"conduct deliveries on her own responsibility"* (Otago Polytechnic, 1988, p.8). The lawyers advised that any consent for student involvement must make clear who held responsibility for the patient (Macalister Mazengarb, Personal correspondence, March 10, 1989).

Several meetings were held with the doctors and they were reminded that New Zealand law (Nurses Act 1977 and amendments) required midwives (at that time) to work under the supervision of doctors. In this course midwifery students would learn midwifery skills and would be directly supervised by registered midwives who would be accountable for the care given by students. The polytechnics did not believe that doctors or their relationships

with their clients would be directly affected by the course, other than involvement in the teaching of students if agreed. Eventually, after several months of negotiation, a consent form was developed collaboratively between the polytechnics and the doctors (Gordon, J. Personal correspondence, June 16, 1989).

This opposition from doctors in Southland was a remarkable example of the paternalistic attitudes held by many doctors at the time. These attitudes were beginning to be challenged by women's groups through the 1980s. However it was the Cartwright Inquiry that really initiated changes that resulted in the legal requirement of all health professionals, including doctors, to be accountable to the consumers of services through the Code of Health and Disability Consumer Rights (Ministry of Women's Affairs, 1989; Health and Disability Commissioner Act 1994). Doctors were to be further challenged in 1990 when the Nurses Amendment Act was passed reinstating midwifery autonomy. Midwives in Southland, as elsewhere, began to offer independent midwifery care and midwifery students were able to obtain increasing clinical experience with these midwives.

A positive outcome from this medical opposition was that we contacted local and national maternity consumer groups to seek their support over this issue. This was forthcoming and women were then involved in the development of the consent form and also contributed to the final curriculum document (personal notes, 1989). This involvement was the beginning of strong relationships between maternity consumer groups and the Otago Polytechnic midwifery programmes. Women, through the maternity consumer organisations, continue to be represented on the Midwifery Permanent External Advisory Committee (PEAC) that was established in 1992 for the Bachelor of Midwifery programme. Women are involved in the selection of students into this programme and they continue to play important roles in the teaching of students through various mechanisms over the three years of the programme. As will be discussed, women also played an important part in assisting the development of the Bachelor of Midwifery curriculum and supporting it through the various accreditation and approval processes.

The Evaluation of Midwifery Education

As mentioned earlier, the Departments of Health and Education planned the evaluation of the five midwifery programmes to run from 1989 to 1991 and the outcome was to drive further decisions about the future direction of midwifery education. However, there were problems with the evaluation from the beginning. There appeared to be some misunderstanding amongst the polytechnics about the evaluation process. Following the October 1989 National Committee meeting of the newly formed New Zealand College of, Karen Guilliland, then President, wrote to the Departments of Health and Education requesting cancellation of the evaluation because polytechnics were not adhering to the evaluation criteria, thus making the process invalid. Waikato Polytechnic and Christchurch Polytechnic (the two A.D.N/Midwifery option programmes) did not distribute the pre-entry questionnaires to their students. Neither institution required their students to complete the pre-requisite year of practice in a maternity facility (this was a criteria for the A.D.N/Midwifery option only). The College asked that separate midwifery courses be established throughout the country in 1991 (NZCOM, 1989a). The NZCOM Annual Report 1989-1990 recorded that the separate courses were in their second year and running successfully with significant support from midwives and consumers. However, Wellington Polytechnic had still awarded its first graduates an Advanced Diploma of Nursing, despite the fact that they had not completed that course. The evaluation continued at that stage (NZCOM, 1990b).

However, the evaluation was overtaken by other events. Nurses refused to enrol in the A.D.N/Midwifery programme, insisting instead on access to the one-year midwifery programme. This demand from students led to both Waikato and Christchurch Polytechnics closing their A.D.N/Midwifery programmes in 1991 and commencing one-year separate programmes in 1992. The polytechnics were able to commence the separate programmes without approval from the Health and Education departments because of the Education Act passed in 1990. Amongst other things this Act removed government control over funded places for health education programmes and opened up a more free-market approach. The Ministries of Education and Health were restructured, the evaluation was never completed and the A.D.N/Midwifery option ceased without any policy decision to do so being made.

The separate midwifery programmes themselves only lasted another few years, as eventually registered nurses were able to enter the direct entry Bachelor of Midwifery programmes. With some credit for prior learning nurses could complete the degree programme in two years instead of three.

Despite their brief time span the separate midwifery programmes were important milestones in midwifery education development. The provision of one year of specific midwifery education instead of the shorter 'option' within a post-basic nursing programme was the first step to raising the profile of midwifery and recognising the potential of midwifery as a major provider within maternity services. It also set the direction for further separation from nursing that would follow the 1990 Nurses Amendment Act. Although the separate programmes began before the legislation changed they used the WHO Definition of a Midwife to set the boundaries of what a midwife needed to learn in order to practise. The curricula used words such as 'autonomy' and 'continuity of care' and follow-through clinical experiences were sought for midwifery students in order to give them an understanding of childbirth as a continuous process for women rather than the fragmented approach taken in maternity service provision at that time whereby a woman's care was arbitrarily divided into antenatal, labour and birth, and postnatal. .

Towards direct entry midwifery education

As discussed in Part Three of this thesis, midwifery separated itself from nursing through the establishment of the NZCOM and development of a philosophy and standards that articulated midwifery as an autonomous profession. At the same time the consumer-driven, Direct Entry Midwifery Taskforce (a sub-group of Save the Midwives) was working towards a new structure for midwifery education. The Taskforce, with the assistance of a grant from the McKenzie Trust Foundation, widely distributed a discussion paper and questionnaire to assess the feasibility of establishing direct entry midwifery education programmes in New Zealand (White Eyres, 1988).

Six hundred and ninety-one replies were received, manly from women and midwives, indicating strong support for direct entry (NZCOM, 1990b). In February 1990 the

Taskforce, in conjunction with Auckland-based Carrington Polytechnic and with the endorsement of NZCOM, released a discussion document and draft direct entry midwifery curriculum (Save the Midwives Direct Entry Midwifery Taskforce, 1990). Eight hundred and twenty six copies were distributed directly by the Taskforce and again the responses were positive. Common themes included: the need for input from Maori and other minority groups; the importance of quality clinical experiences with a focus on normal birth and continuity of care; modular structures to enhance distance learning and flexibility; and support for an apprenticeship model of clinical experience (Save the Midwives Direct Entry Midwifery Taskforce, 1990). This draft curriculum framework was a useful resource to those institutions that went on to develop direct entry midwifery programmes for approval by the Nursing Council.

In August 1990 Section 39 of the Nurses Amendment Act paved the way for direct entry midwifery. Section 39 was an experimental clause that required the Nursing Council to inform educational institutions of any amendments necessary to achieve approval if the programme was initially turned down by the Council (Strid, 1991). Four polytechnics submitted curricula, including Carrington. The Nursing Council approved three initially and the Minister of Health later agreed to fund two programmes, one at Auckland Institute of Technology (AIT) and one at Otago Polytechnic. Carrington's programme was approved by the Nursing Council, but the Minister's decision established one programme in the North Island and one in the South Island (Nursing Council, personal correspondence, November 26, 1991). AIT was approved over Carrington as the North Island programme because of its prior experience providing the one-year Diploma of Midwifery programme.

Both approved programmes were three-year programmes but AIT awarded a diploma on completion while Otago developed a Bachelor of Midwifery degree programme. Both were to undergo extensive evaluation over the next three years before funding was approved for further intakes of students and further programmes elsewhere in New Zealand. I will discuss the development of direct entry midwifery at Otago Polytechnic shortly, but first I will turn to the establishment of the Independent Midwifery Service at Otago Polytechnic.

Otago Polytechnic Independent Midwifery Service

Although midwifery autonomy was restored in August 1990 there were very few practising independent midwives for the first few years. Dunedin had one full-time domiciliary midwife and a small group of part-time domiciliary midwives, the Dunedin Domiciliary Midwives Collective, mentioned in the introduction to this thesis. Thus when Otago Polytechnic wanted to provide its post-nursing registration Diploma of Midwifery students with clinical experience that more appropriately reflected midwifery's new scope of practice than the then common fragmented hospital midwifery practice, there was nowhere to find this. I proposed to the Head of School of Nursing Alison Dixon, that we establish our own midwifery service to provide 'independent' midwifery care to women in Dunedin. Alison was supportive of the concept and I put together a proposal that eventually saw the Polytechnic employ two more midwives, one half-time and one full-time. The other fulltime midwife, Margaret Gardener, and I shared our teaching and practice responsibilities. The part-time midwife, Rhondda Davies, worked only in the midwifery practice.

Together the three of us established a practice model for autonomous practice and operated under the name 'Otago Polytechnic Independent Midwifery Service' (IMS). We developed a philosophy from which to work and shared the care of women between us. This was necessary because two of us also had teaching responsibilities and Rhondda also worked half time at the local maternity hospital. Our aims were two-fold. First, to develop a community-based model of midwifery practice that provided continuity of care to women and second, to involve students in women's care so they could learn midwifery in this alternate model.

We rented rooms in the centre of town, produced promotional material, liaised with all the general practitioners in town, made contact with pharmacists and laboratories, discussed referral processes with obstetricians and other specialists and began to advertise our services. We claimed fee-for-service payment from the Maternity Benefit Schedule and these funds went towards our salaries and overhead costs.

The service was launched early in 1991 and we were quickly inundated with bookings from women who eagerly embraced this new model of care. It was a huge learning curve for all of us. Although Rhondda and I both had experience as domiciliary midwives, the IMS offered both home and hospital births and total midwifery care as well as shared care with general practitioners. The latter was the most popular choice for women in the early 1990s as the shift from doctor-led care to midwife-led care was too great for many women at that time. The funding arrangements from 1990 to 1996 allowed women to choose shared care until this stopped with the introduction of the modular, Lead Maternity Carer system in 1996 that was discussed in Part Three.

The IMS worked successfully for six years. It closed at the end of 1997 because by then Dunedin had an oversupply of caseloading midwives and it was no longer necessary for the polytechnic to provide this service. Over those six years the service changed and evolved as we learned more about our roles and working together. It quickly became clear that women preferred to know the midwife who would be with them at the birth and our plan to share care between the three of us evolved to most women meeting only two midwives. This put more pressure on us, and it was difficult to sustain our teaching commitments with the 'on call' requirements of midwifery practice. Eventually the IMS employed more fulltime midwives in the practice and the teaching staff took smaller caseloads. Another change across the six years was the increasing number of women choosing midwife-only care rather than shared care with a doctor.

The IMS was a successful model and it helped provide a model for other midwives as they established themselves as community-based caseloading midwives. The IMS also met our objective of providing role models of autonomous practice and experience in caseload midwifery to students. It was an important mechanism for both the diploma students and the direct entry midwifery students and the teaching and clinical experience they gained through the IMS was invaluable. However, as midwifery developed in New Zealand we had increasing opportunities to access this kind of experience for students throughout New Zealand. The local maternity hospital established a caseload model and Dunedin midwives were quick to take up opportunities for independent practice during the 1990s. When we

closed the IMS in 1997 there was no shortage of clinical experience for students and a growing commitment from midwives to support student learning in this way.

I will move on now to look at the development of a framework for midwifery education and the establishment of direct entry midwifery programmes.

Developing a National Midwifery Education Framework

A debate about whether midwifery should be a degree or diploma programme occupied the profession in the early 1990s. Nursing held a conference, 'Vision 2000', in March 1991 and this provided midwives with an opportunity for national debate on education issues. The intention of the conference was to develop a national framework for nursing and midwifery education; however it was soon evident that a combined framework would not meet midwifery's needs.

Midwives separated from the main conference and began the development of a national framework for midwifery education (Pairman, 1991). This beginning National Framework recognised the foundation of the Treaty of Waitangi in all aspects of midwifery; identified the implications of professional autonomy on the regulation of midwifery, the role of the College and the pre-registration midwifery education curricula; and set out expectations regarding the clinical experience to be offered to pre-registration midwifery students. The degree/diploma debate was identified as an area requiring further discussion by the whole profession (Pairman, 1991).

This debate occurred in each region of the College throughout the remainder of 1991. In February 1992 the NZCOM held an Education Workshop in Wellington, bringing together midwifery educators, practitioners, regional chair people and consumers from throughout New Zealand. A number of workshops were held, one of which further developed the National Framework for Midwifery Education (NZCOM, 1992). This Framework proposed that the three-year midwifery pre-registration programmes should be undergraduate degree programmes. It also set out guidelines for post-registration and postgraduate midwifery

education through continuing education programmes, masters and doctoral programmes (NZCOM, 1992). Following this workshop AIT moved to convert its direct entry diploma programme to a degree programme. Thus all of the first direct entry graduates in New Zealand in 1994 graduated with Bachelor's degrees.

This Framework was further refined in May 1994 at the NZCOM National Education Workshop in Palmerston North. Representatives from each region of the College as well as midwifery educators, practitioners and consumers, endorsed the 1992 Education Framework and developed a strategic plan to further implement the framework. At this workshop the main issues involved the following:

- *Achieving entry to the midwifery profession by undergraduate degree only by 1997 (this meant closing remaining one-year diploma programmes for nurses entering midwifery and providing a route for them through the direct entry degree programme frameworks);*
- *Clarifying the relationship between New Zealand Qualifications Authority (the government agency responsible for approval of polytechnic based degree programmes) and NZCOM;*
- *Developing competence-based practising certificates;*
- *Removing the experimental status of direct-entry programmes;*
- *Developing post-registration midwifery education, including obtaining funding;*
- *Funding clinical experience for pre-registration students;*
- *Reviewing registration requirements of overseas midwives;*
- *Gaining midwifery representation on relevant education bodies such as the Nursing Council;*
- *Communicating midwifery education issues within the College* (NZCOM, 1994).

These decisions were ratified at the NZCOM Annual General Meeting in August 1994. Interestingly several of these issues relate to midwifery regulation and provide an example of NZCOM's interest in influencing midwifery regulation in the absence of a separate regulatory authority for midwifery. This discussion will be picked up in Part Five of this thesis.

Midwifery education consolidated during 1994 to 1998. Further three-year direct entry degree programmes were commenced at Waikato and Wellington Polytechnics in 1996 and Christchurch Polytechnic in 1997. One-year diploma programmes ceased in Otago (1992), Christchurch (1996), Waikato and Wellington (1998), and Auckland (1999). Postgraduate midwifery programmes commenced at Massey University (1993), Victoria University of Wellington (1994), AIT [by now Auckland University of Technology, AUT] (1999) and at Otago Polytechnic in 2000.

The post-registration midwifery education section of the Framework was developed extensively through 1998. In March NZCOM invited midwifery educators, practitioners, regional chair people, consumers, and representatives of the Nursing Council, Ministry of Health, Ministry of Education, Clinical Training Agency, and Women's Health Managers to a workshop. This workshop developed a draft, post-registration, midwifery education framework and established a small working group, which I led, to carry on the project. The Framework was developed further at a meeting in April 1998, circulated to all regions of the College and ratified at the Annual General Meeting in Auckland in August 1998. Further detailed work was undertaken at a meeting of the working group in August 1998 and then again in September 1998.

The National Midwifery Education Framework 1999 (Pairman, 2000) combines the earlier work on pre-registration midwifery education with more recent developments in post-registration midwifery education. It brings together all aspects of the Framework for Midwifery Education developed and ratified by the College to date.

I will turn now to a brief discussion of direct entry midwifery at Otago Polytechnic, but I will use examples from my experiences in Otago in the discussion of themes that follows.

Otago Polytechnic Bachelor of Midwifery Programme

There were two pieces of legislation passed in 1990 that opened the way for Otago Polytechnic to offer a Bachelor of Midwifery programme. These were the 1990 Nurses Amendment Act, which provided a mechanism for direct entry midwifery programmes

under the 'experimental' clause of the Nurses Act, and the 1990 Education Act that made it possible for tertiary providers other than universities to offer a degree. Under the leadership of Alison Dixon, Head of the Nursing Department, nursing decided to replace its three-year diploma of nursing programme with an undergraduate degree. It seemed sensible to me that midwifery should offer a direct entry programme through an undergraduate degree as well. I believed that in creating its identity as a profession midwifery should have a system of education that was on a par with nursing and medicine. I thought that a degree programme would be better preparation for autonomous midwifery practice where midwives needed to work from a sound knowledge base and be able to defend their practice in an often-hostile environment, particularly in the early years of midwifery autonomy.

However, my thinking was out of step with many midwives and women (consumers) at that time. Whilst we could all agree that midwifery needed direct entry education programmes if it was to fully develop as an autonomous profession, we did not agree on the form this education should take. Many women (consumers) and midwives saw degree programmes as elitist, academic, patriarchal (especially the word 'bachelor'), and mono-cultural. There was concern that such a structure would produce midwives who were too 'academic' and not 'with women' and that it may inhibit some women, especially Maori and Pacifica women from entering midwifery. For some of these women midwifery was seen as a 'calling' rather than a career (Strid, J. Personal communication, June 1991). On the other side of the debate I argued that the degree structure itself did not prevent the development of a women-centred education model or practitioners who would work 'with women'. As most other health professions were moving from diplomas to degree level education I did not want midwives to be disadvantaged in the future if they did not have a degree.

The degree/diploma debate was discussed intensively and although the College supported entry to the midwifery profession by degrees, in the first instance Otago Polytechnic was the only institution to submit a degree programme for approval. Within two years of this programme commencing the midwives and women were sufficiently reassured to let the matter rest. AIT moved its diploma programme to a degree in 1993 so that the graduates

from the first two direct entry programmes all entered the profession with a midwifery degree.

In Otago our degree framework was devised in association with nursing. Although we identified a separate philosophical base in regards to professionalism, the educational philosophy that underpinned these two curricula was based on critical theory and feminism and the curriculum frameworks legitimised technical, practical and emancipatory knowledge (Otago Polytechnic, 1991). The framework for both degrees was the same, identifying 'streams' of learning around knowledge, research, practice, behavioural science, bioscience, cultural studies and women's studies.

However, the midwifery curriculum also used the partnership between women and midwives to frame its midwifery knowledge and practice papers. Thus in year one the course focused on the woman and her experiences of childbirth and maternity services. Year two focused on the student midwife learning midwifery-specific skills and year three focused on the midwife and woman together in partnership. Therefore papers taught in year one were foundational and practice papers explored women's experiences of childbirth, with students 'following through' women in the role of support persons. In year two the focus moved to development of midwifery skills and knowledge and the student took more of a 'hands on' role in practice that was both community-based and hospital-based. In the final year the focus moved to the midwife as an autonomous practitioner in partnership with women and clinical experience involved almost the entire year working alongside midwives in caseload practices in various settings, including rural.

To begin with midwifery and nursing students shared a number of what were considered the 'foundational' papers such as behavioural science, physiology and research. However, it soon became clear that there were differences in the needs of the students and their focus. Midwifery students tended to be older women with extensive life experience and although they were far out numbered by younger nursing students they still made their presence felt. They wanted a more specific midwifery focus to these 'shared' papers that were often taught by nurses. As the programme has evolved we have redeveloped papers to integrate

these 'foundational' concepts into practice and the two degrees now look entirely different. This development was influenced not only by students but also by our growing understandings of midwifery and our desire to integrate theory with practice in ways that reflected the changing role of midwives in New Zealand.

Despite the evolving differences in the two curricula, the Nursing Department at Otago has always been very supportive of midwifery's goal of self-determination. The Department renamed itself the Nursing and Midwifery Department in 1994 to acknowledge that we are separate professions and the Department has remained supportive since we became a separate School of Midwifery in 2000. Midwifery at Otago Polytechnic owes much to nursing and has benefited from nursing's longer academic tradition, as we develop ways to articulate midwifery's evolving knowledge.

I will leave this historical overview now and move on to discuss three themes that can be drawn from this historical account. These are: promoting autonomy, partnership and women centred care; promoting collaboration; and enhancing professionalism.

Promoting autonomy, partnership and women centred care

As I have shown, the separation of midwifery's entry-level education from nursing was an important component in the evolution of midwifery's professional identity. While midwifery's main reason for promoting a one-year midwifery programme for nurses in the late 1960s was to improve the standard of midwifery education and better prepare midwives for practice, the closure of the St Helen's midwifery programmes and the transfer of nursing education from hospitals to tertiary education institutions set a new priority for midwifery.

Midwifery education was transferred along with nursing into the tertiary education system, where it was defined as 'advanced nursing practice', and located within advanced nursing programmes. Whilst purporting to raise the educational standard of midwifery, many midwives, students, midwifery educators and midwife-employers disagreed. Rather than

providing more theory and clinical experience, the A.D.N midwifery option was perceived to downgrade midwifery education through its definition as 'advanced nursing practice'; reduction in clinical hours; prerequisite obstetric nursing experience; and the impact on midwifery students of having to complete two programmes, the Advanced Diploma in Nursing and midwifery registration, in one academic year of approximately 10 months (Midwives Section, 1984; NZNA, 1987a; Midwives Section, 1987a). The process of trying to change government and nursing policy on midwifery education in order to achieve one-year tertiary-based midwifery programmes, separate to the A.D.N, helped midwifery to clarify why midwifery education was important.

Separate identity

Midwifery's argument that midwifery education should be separated from the A.D.N and established as a separate one year course in the tertiary education sector was twofold. Firstly, the A.D.N was perceived as inadequate preparation for midwifery practice in the context of the 1980s where midwives in rural areas were expected to practise with 'relative autonomy' and the maternity services as a whole were characterised by complexity that arose from increasing medical and technological intervention alongside increasing demands from women (consumers) for more 'home-like' and less interventionist care (Hill, 1982; Donley, 1986).

Secondly, midwifery increasingly began to understand itself as a profession separate to nursing and the argument for separate education was intertwined with the argument that a midwife was 'a person' first, not a nurse. As a separate profession, midwifery needed its own education preparation. The logical conclusion of this argument would be the establishment of direct entry midwifery programmes, but most midwives did not support direct entry midwifery initially and some expressed confusion and concern about direct entry midwifery education even as recently as 2004 (Midwifery Council, 2004a).

This confusion seems to be about the distinctions between nursing and midwifery. The majority of midwives practising in New Zealand today learned basic assessment and practical skills through the prerequisite nursing registration programme and therefore

consider these skills to be nursing skills. It has taken time for some midwives to be convinced that these basic skills are largely generic and shared with other disciplines such as medicine, and that they can be learned outside of a nursing programme. Nevertheless their identity as 'nurse' has been just as important to many midwives as their identity as 'midwife'. As will be discussed in Part Five, the establishment of a separate regulatory authority for midwives in 2004 clarified this issue for many midwives, as they had to choose for which registration, nursing or midwifery, they wished to maintain competence (Midwifery Council 2004b).

Thus even while claiming definition as a 'person' first, rather than 'nurse', in order to identify its differences to nursing, midwifery demonstrated confusion about its linkage with nursing in the later discussions about direct entry midwifery. It has taken ten years of direct entry midwifery and the establishment of the Midwifery Council of New Zealand as the regulatory authority, for most midwives to fully appreciate themselves as a separate profession, albeit that many entered midwifery through a pathway from nursing.

Fortunately for midwifery there were many midwives, such as Karen Guilliland, who understood this distinction with nursing much earlier, and these midwives promoted midwifery as a separate profession to nursing through the political activity of the Midwives Section (Tully, 1999). This Midwives Section political activity lead first to the establishment of the separate one-year post-nursing registration midwifery programme and later, through the New Zealand College of Midwives, to support for direct entry midwifery education.

As discussed in Part One of this thesis, maternity consumer activists during the mid-1980s called for midwifery autonomy and the re-establishment of the 'traditional' midwife (in line with the ICM definition), because they believed that such midwives would be more likely to support women's calls for more women and family-centred maternity care (Strid, 1987; Dobbie, 1990). These women also saw direct entry midwifery education as essential because they did not believe it was possible to produce the type of midwife they sought through the education programme of another discipline, nursing, with its different

philosophical base and cultural values (Save the Midwives Direct Entry Midwifery Taskforce, 1990). The Taskforce stated:

> *Although nursing education of today is centred on wellness, nursing arises out of either a disruption of wellness, or the prevention of that disruption. Neither applies to midwifery with its focus on normal pregnancy and childbirth, and the role of supporting the woman and her whanau* [family] *during a normal physiological event* (Save the Midwives Direct Entry Midwifery Taskforce, 1990, p.8).

Nevertheless, when the Midwives Section joined maternity consumer activists in a combined campaign for the re-establishment of midwifery autonomy a deliberate decision was taken to first address the urgent need to improve midwifery education by seeking separate midwifery education for nurses, then to seek midwifery autonomy and ultimately to seek direct entry midwifery education (NZCOM, 1989a).

Midwifery autonomy was seen as the mechanism through which midwifery could finally reclaim its professional identity and work in the full scope of practice as defined by ICM. Intrinsic to the notion of midwifery autonomy was the ideology of the midwifery model which focused on childbirth as a normal life event for which women required midwifery support and guidance but not necessarily medical intervention (Katz Rothman, 1984). As discussed earlier, curricula for the separate one-year midwifery programmes reflected midwifery's beginning understandings of this philosophical position, and thus these programmes were an important transition in midwifery's evolution from workforce to profession through the 1980s to 1990s.

However, it was the reinstatement of midwifery autonomy through the 1990 Nurses Amendment Act and the concurrent mechanism to establish direct entry midwifery education, which really marked the separation of midwifery from nursing. It was essential to midwifery professionalisation that these new direct entry midwifery programmes produced the kind of midwife that the profession and women wanted, and therefore these programmes focused on midwifery autonomy, partnership with women and women-centred care. Direct entry midwifery programmes gave midwifery the opportunity to (re) constitute

midwifery expertise as 'normal' pregnancy, 'partnership' practice and 'women centred' care and to produce midwife graduates that would be able to work independently of doctors in the provision of midwife-led care in continuity frameworks.

Philosophy

In identifying the underpinning philosophy for midwifery education as partnership with women and women-centred care, midwifery had to explore what these concepts meant in relation to professional autonomy. While midwifery claimed, and was granted, midwifery autonomy in order to control our scope of practice and thereby provide an alternative for women to the medical model of childbirth, we wanted to frame our professional identity and practice as 'in partnership' with women. In a partnership, autonomy is reframed as relational, rather than individual. By this I mean that while midwives and women make individual autonomous decisions about themselves, as partners in women's care midwives and women make decisions about care together. However, the notion of professional autonomy is important in that it means the midwife/woman pair is autonomous with the freedom to make decisions about the woman's care together, and without reference to medicine.

Common understandings of autonomy are based on the notion of articulate, intelligent individuals who are used to making decisions about their lives and have the resources necessary to choose from a range of options (Sherwin, 1998). These understandings underpin the concept of informed choice and decision-making that is now a legislated right of individuals (patients) in New Zealand's health services (Health and Disability Services Code of Consumer Rights, 1996). However, such an approach does not take into account the numerous contextual factors that may prevent clients/patients from experiencing real choice or for professional judgments to carry authority. For example, choices can often only be made from the options presented to the client/patient and these maybe restricted by factors such as practitioner preference and resource allocation. Professional autonomy can be limited in contexts that are not supportive of the professional's capacity for independent judgment as is often the case in large and complex maternity units (Kirkham, 2000).

New Zealand midwifery has the legislative right to make autonomous professional judgments, both as individual practitioners working with women and as a profession with self-governance. The contextual structure of New Zealand's primary maternity services supports midwifery autonomy with its focus on Lead Maternity Carers being directly accountable for the care of their clients. However, was discussed in Part Three, midwives have to negotiate their professional judgments with regard to the Section 88 (previously Section 51) referral guidelines and, depending on their individual sense of professional autonomy and their particular local context, these referral guidelines can be used to either enable or constrain midwifery professional judgments.

Critique from feminist scholars has suggested that autonomy is better understood, not as individual free agents making choices, but as complex webs of personal and institutional relationships that make possible or hinder the exercise of autonomy (Sherwin, 1998). According to this feminist critique women's experiences involve networks of relationships and interdependencies that are often not chosen or optional. There are also cultural differences. For example, in Maori culture individuals are closely connected to their whanau (family) and larger iwi (tribe) and autonomy and decision-making is exercised collectively rather than individually. Relational autonomy recognises that individual autonomy is socially constructed, and that the capacity and opportunity for autonomous action depends on particular social relationships and power structures within which individuals are embedded (Sherwin, 1998). As individuals are never fully independent the relational understanding of autonomy seeks to support self-determination within a context of interdependency.

The concept of relational autonomy is useful to midwifery's understanding of partnership with women. In this partnership model of midwifery practice, the autonomy of the profession and of individual midwives is expressed though the relationship of partnership. As will be discussed in Part Five of this thesis, professional autonomy was granted to midwifery by society through both the 1990 Nurses Amendment Act and the Health Practitioners Competence Assurance Act 2003. It is this social contract that gives midwifery the right to self-governance and professional authority. As mentioned, the

maternity service context in New Zealand supports the authority and accountability of Lead Maternity Carers, of which midwives are one group. However, both the midwifery profession and individual midwives express their professional autonomy through partnership relationships with women.

In midwifery partnerships differences between partners, including power and knowledge, are recognised and overt. Partnership works from a sense of equality and therefore midwives work with women to negotiate how their relationships with each other will work; what expectations each has of the other; how decisions will be made; how individual needs will be met; and how power can be balanced and shared. Thus, in a partnership relationship a midwife does not exercise her professional autonomy independently of the woman. Instead they exercise autonomy together, in relation to each other, and are accountable to each other. Midwives and women work together to find ways to facilitate meaningful self-determination within the context of this partnership.

Learning and teaching strategies

In designing curricula for the new direct-entry midwifery education programmes midwifery educators sought to integrate these notions of partnership, women-centred care and autonomy through all aspects of the curricula. While wanting to ensure a knowledge and skill base that would support midwives to provide caseload midwifery independently in the community, educators wanted to ensure that midwifery students embraced midwifery's philosophy and core values so that these became part of the student midwife's professional and personal identity.

Thus midwifery partnership was reflected throughout the curriculum design and underpinned the learning and teaching strategies of the Otago Polytechnic Bachelor of Midwifery programme. The curriculum was developed in collaboration with women (consumers), and practising midwives and since that time the Otago Polytechnic School of Midwifery has developed partnerships with women and midwives that involve them in student selection, teaching, student assessment, clinical teaching, programme development,

programme monitoring and strategic planning (Pairman, 2001; Davis & McIntosh, in press).

The curriculum is structured to reflect midwifery partnership with its first year focus on the woman, second year on the midwife and third year on the midwife/woman partnership. Along with this students and teachers are seen as partners in the joint endeavour of developing midwifery knowledge and skills. Thus the course is structured to enable maximum flexibility for students while at the same time there are clear expectations of student responsibility and accountability for their own learning.

Theoretical knowledge is built from practice through the used of scenario-based teaching whereby 'real life' practice examples are used to draw out and explore the areas of knowledge required for autonomous midwifery practice and the development of professional judgment. Group learning strategies are used along with individual and self-directed modes of learning. The teacher is seen as a facilitator and a resource rather than an 'expert'.

Clinical experience is structured around continuity of care in all clinical placements, other than six-months of secondary and tertiary hospital-based experience undertaken in second year. Students are allocated to women who volunteer or they are allocated to midwives in an apprentice-style model. In all clinical practice experiences students are expected to 'follow through' women and share their experiences of the childbirth continuum from antenatal care through to six weeks postpartum. Students follow the women – to their homes, community midwifery clinics, hospitals, laboratories, screening tests - and across three years take on more of the 'hands on' care under the direction and supervisions of the woman's midwife. In the final year students are placed one-to-one with case-loading midwives and they work alongside these midwives for long periods of up to 14 weeks consolidating their knowledge and skills in a context that reflects New Zealand's style of independent and caseload practice. Thus the curriculum aims to produce midwives who are both competent and confident upon graduation. As most New Zealand women still birth in secondary and tertiary maternity units, students gain extensive experience in these settings as they follow women and work alongside them and their midwives. However, most

students gain some homebirth experience and all students work in primary maternity facilities and rural maternity settings.

The overall aim of the programme is to develop professional judgment, or what Coles (2002) and White (1996) describe as 'practice wisdom'. Coles defines this as a form of knowledge,

> *Which is not formally taught and learnt but is acquired largely through experience and informal conversations with respected peers. Wisdom develops through 'the critical reconstruction of practice', including deliberation, which is distinguished from mere reflection. Professionals need to engage in the appreciation of their practice – not just to understand what informs their own practice but to consider critically the contestable issues endemic to practising as a professional* (Coles, 2002, p.3).

Professional judgment is what distinguishes professional practice from technical work and involves both explicit and tacit, or intuitive, knowledge. Explicit knowledge can be taught but intuitive knowledge develops through observation, practice and reflection. Practice wisdom is a way of thinking about practice that is inseparable from professional judgment which is the expression of this thinking through action (Coles, 2002).

To develop practice wisdom as a basis for professional judgment theory and practice are integrated throughout the programme. Critical thinking and reflection are intrinsic to scenario-based learning and teaching. Immersion in practice with midwives, especially in year three, is an important mechanism for talking through the learning that occurs in practice and for reconstructing and making sense of this learning with midwife colleagues and midwifery teachers. This learning is situated in a context of partnership with women and midwifery professional autonomy.

Promoting collaboration

The first formal experience that midwifery educators had of working together was through the Department of Education initiative, the Lopdell House workshop that preceded

development of the separate midwifery programmes. This opportunity to share ideas and resources and clarify philosophy and aims was of great benefit to midwifery educators, who until that time had operated largely in isolation to the wider profession.

Since then the College of Midwives has actively worked to promote and facilitate collaboration between midwifery educators, women (consumers) and the profession, through a number of mechanisms. I have already discussed the first two important collaborative processes, the degree/diploma debate and the development of a national framework for midwifery education (Pairman, 2000).

The College facilitates an annual meeting of all midwifery educators with representatives from key stakeholder groups such as the profession, consumer groups, students, employers, the regulatory authority and the government, through the Ministry of Health. These meetings aim to ensure consistency of midwifery education across the country and to provide another mechanism for the reciprocal sharing of information that can benefit the programmes.

Similarly the College and consumer groups are formally represented on the external advisory committees of all programmes and thereby play a vital role in the development and monitoring of midwifery education programmes.

The central purpose for these collaborative processes is to maintain relationships between programmes and the wider community of stakeholder groups. In particular midwifery aims to ensure that education programmes are relevant and reflect the values of the midwifery profession, the context of practice and the knowledge, skills and attributes that the profession and women identify as necessary for midwives practising from a base of partnership, autonomy and women-centred care. In particular these collaborative processes seek to ensure that midwifery programmes do not evolve in isolation but are connected to the profession and to women.

Enhancing professionalism

The taking on of midwifery's values, knowledge, skills and attitudes that is professionalism, begins in the pre-registration programmes but continues throughout the working life of a midwife.

New Zealand midwifery has turned its attention to this aspect of professionalism relatively recently and as a direct result of the establishment of the Midwifery Council of New Zealand in 2003, as the regulatory authority for midwifery. This will be discussed more fully in Part Five of this thesis, and so I will only briefly mention the various strategies that midwifery is using to enhance professionalism of midwives after registration.

When midwifery autonomy was first reinstated the College put significant energy into running short courses to enable midwives to update their clinical skills in order to prepare them for autonomous practice. Because midwives had practised in mostly in hospitals and in roles where they were subservient to medicine, many had lost certain clinical skills such as perineal repair, or had never developed these skills because they were considered the tasks of doctors. In the years immediately following 1990 there was a flurry of attendance at short courses to update skills in suturing, intravenous cannulation, neonatal resuscitation and examination of the newborn, to name but a few. As well midwives organised courses in small business management, documentation, informed choice and decision-making, and in discussion of practice models and processes for referral to secondary services. In other words, midwives sought to prepare themselves practically for autonomous midwifery practice.

The other learning came from practice and as discussed in Part Two and the accompanying portfolio pieces, its was midwives' experiences of working in partnership with women that had the most influence on how midwifery began to construct our scope of practice, professional identity and knowledge. Autonomous practice and continuity of care challenged midwives' 'taken-for-granted' assumptions about practice and, with women, they began the process of (re)constructing midwifery's knowledge base and (re)constituting midwives as specialists in normal birth.

As midwives explored practice in these ways, formal postgraduate midwifery programmes were established and midwives were encouraged to undertake research that would support the articulation of this new knowledge. Midwives now have access to master of midwifery programmes and doctoral programmes, and although still small, there is a growing body of evidence about the unique practice of New Zealand midwives. The unique contribution that New Zealand midwifery has made and is making to the international midwifery community is our evolving understandings of midwifery partnership and autonomous midwifery practice. As this knowledge is shared the professionalism of midwifery is enhanced, not only in New Zealand but elsewhere.

Midwifery education as a professionalising strategy

As described in Part Three of this thesis, professionalism involves internalisation of the profession's values and practices by its members. It involves commitment to the profession, dedication to providing 'good' care and belief that the work of a profession has value to society. For New Zealand midwifery, professionalism is the expression of partnership - our social contract with women.

Professionalism does not stop with attainment of formal entry to a profession by registration or licensure; it involves the ongoing work of the professional in the practice of profession. Thus it involves lifelong learning and continual commitment to improving skills and expanding one's knowledge base. Education, therefore, lies at the heart of professionalism and it is a central professionalisation process.

New Zealand midwifery has used midwifery education as a focus for developing an identity separate to nursing. Women played an important role in articulating midwifery as separate to nursing and providing midwives with a vision of what their practice could be. However, midwives and women did not initially agree on the form that direct entry midwifery should take, and debated the implications of providing entry level education through a degree or a diploma. As Abbott (1988) contends, the context within which jurisdictional disputes between professions take place will affect the outcome of these struggles over boundary

demarcation between professional groups. Thus, in a context where nursing was attempting to enhance its professional status through degree-level education and where medicine was already firmly established from a base of university education, midwifery needed to make its claim for 'expertise' from the same level of programme so as not to lose ground in jurisdictional disputes. By contrast, much of midwifery's vocal consumer base did not agree with degree-level education as it was perceived as elitist and likely to produce midwives who were more interested in a career than they were in the 'calling' of midwifery (Strid, J. personal correspondence, June 1991). The challenge for midwifery educators was to construct a theoretical knowledge-base that underpinned midwifery as an autonomous form of practice while at the same time locating this knowledge-base in a philosophy of midwifery partnership and women centred care.

The Bachelor of Midwifery degrees that evolved were deliberately developed in collaboration with women, the profession and other stakeholder groups, in order to ensure that the underpinning philosophy was woven through every aspect of the programmes. In this way students were immersed in midwifery professionalism through their education programmes and were able to demonstrate a way of practice that alleviated the previously held fears of consumers that they would not be able to practise 'with women'.

Midwifery education evolved in response to midwifery's developing understandings of partnership and autonomy that arose from practice, and as midwives began to identify and explore this new knowledge, formal processes were established to assist the generation and articulation of new knowledge through postgraduate education. While Abbott (1988) contends that further elaboration of a profession's knowledge base is often in response to competition from other groups over jurisdictions, in New Zealand this articulation of midwifery's knowledge base began after it had secured the right to practise independently, and as a result of that practice.

New Zealand midwifery has reframed midwifery practice to mean partnership and in so doing has made clear to the public and to women what distinguishes it from other professions such as medicine and nursing. In this way midwifery education has been a mechanism to strengthen midwifery's' claim of jurisdiction over normal childbirth.

Challenges for the future

While midwifery's claim to jurisdiction over normal childbirth seems to be in a state of 'temporary stability' at present, there are challenges for education that may lead to destabilisation of the profession as the result of external influences. Chief amongst these is the government's direction on tertiary education, expressed through its agent, the Tertiary Education Commission, in its strategic plan for 2002 – 2007. In the foreword to the strategy the Associate Minster for Education, Steve Mahary, makes it clear that government funded education programmes will need to be consistent with the overall strategy (Tertiary Education Commission, 2002). Key goals of the strategy include; stronger linkages with business and other external stakeholders; increased responsiveness to the needs of, and wider access for, learners; greater collaboration and rationalisation; increased quality, performance, effectiveness, and efficiency and transparency.

A number of as yet unresolved questions and possible implications arise for midwifery education. If funding support depends on links with businesses and external stakeholders, are New Zealand's health services likely to see midwifery as a priority? If increasing responsiveness and access for students leads to developments in flexible delivery modes and distance learning, how will this impact on the development of midwifery professionalism and the collaborative and interactive process of midwifery education? Does greater collaboration and rationalisation also mean amalgamation of schools of midwifery and if so, how will this impact on midwifery professionalism? If increased quality and performance also means that funding is provided on the basis of 'success', how does this impact on midwifery's need to maintain high standards which inevitably seem to led to failure of some students? If postgraduate funding is based on the quality and quantity of research outputs, how does midwifery's emerging research culture compete for research funding with other more established disciplines such as nursing and medicine?

These questions are beginning to be explored by New Zealand midwifery. As a small profession with very small schools of midwifery, we are vulnerable to calls for

amalgamation and rationalisation. From five schools of midwifery there is the possibility of amalgamation to two; perhaps one in the North Island and one in the South.

Conflict already exists between the professional standards of midwifery programmes and the consumer focus of many of the tertiary institutions in which midwifery programmes are located. Professional judgments of student failure can be challenged and overturned by the institutions, particularly if funding relies on successful completion. There is potential for the profession to lose control over standard setting and find that these standards are being set by others or that the student-centred climate of 'customer service' enables students to challenge and overturn grades through processes of appeal.

Flexible modes of delivery are the new mantra in tertiary education in New Zealand, and these will pose challenges for midwifery, whose main mode of facilitating learning at present is through small group, face-to-face exploration. This is considered important to the socialisation of students into the profession and in the development of communication and conflict resolution skills (Faison, 2003). Learning to accept and work with 'difference' is an important aspect of midwifery education and midwifery educators are asking how this will occur if students access midwifery education programmes from remote places and in isolation, and where discussion may occur on-line rather than face-to-face. Innovative solutions need to be sought and there is an urgent need for research into the impact on professionalisation for students in health programmes who complete pre-registration programmes in distance learning and flexible delivery modes (Faison, 2003). These and other questions face midwifery education in New Zealand today. The central challenge will be to maintain education's alignment with the profession and with women in this changing context of education.

This brings to a close my discussion of New Zealand midwifery's fourth key professionalising strategy, midwifery education for autonomy. Before I move on to look at the last strategy, self-regulation within midwifery professional frameworks, I will introduce the portfolio of work that is associated with Part Four of this thesis.

Linking the portfolio

As in previous parts of this thesis, the following portfolio provides samples of work that develop aspects of midwifery education as a professionalisation strategy. The first is a the New Zealand College of Midwives National Framework for Midwifery Education, prepared by me as a culmination of work undertaken by many midwives over ten years of thinking and discussion about midwifery education for New Zealand. This framework was published in the New Zealand College of Midwives Journal in 2000.

The second piece was published in the Journal in 2001 and records a speech I gave at the International Confederation of Midwives Asia Pacific Region conference in Bali in 2000.

Published in the same year was the third piece, a report of research undertaken by me as part of this doctorate and assisted by a midwifery student, to explore the practice locations of midwifery students after graduation, and to identify what influenced these practice choices.

The final piece is a paper based on a Keynote address I gave at the NZCOM biannual conference in 2004, tracing the changes in midwifery education in New Zealand across a century. This article has been accepted for publication in two parts in the College Journals for October 2005 and April 2006.

Each of these four pieces provides a different focus on midwifery education as a professionalising process, and as a strategy to help move midwifery from a workforce to a profession. The scope and diversity of these works reflects the diversity in midwifery education. As I have described, midwifery education is a central process by which midwifery identifies its unique characteristics and the contribution it makes as a profession.

Education is not only about preparing midwives to enter the profession, it is also about helping the profession to identify our core values and how we want to see these expressed in practice. Midwifery education is a mechanism through which these core values and expectations can be shared with students and the wider profession. It is also a mechanism

through which new knowledge can be developed and it contributes in an important way to ongoing midwifery professionalism.

Like the other key strategies already explored, midwifery education integrates midwifery partnership through its processes of curriculum development, teaching and learning, assessment, monitoring and advice. Midwifery education is integrated with practice to ensure its continuing relevance to the profession and to women. It is this integration of partnership, practice and education that has made it a successful strategy for midwifery professionalisation in the move from workforce to profession.

Following this portfolio, I move on to Part Five of this portfolio, midwifery regulation. That is followed by the conclusion to the thesis, which is located in Part Six.

Part Four: Midwifery Education Portfolio

List of portfolio pieces

Pairman, S. (2000). New Zealand College of Midwives Education Framework 1999. *New Zealand College of Midwives Journal, 22,* June, 5 –14.

Pairman, S. (2001). International trends and partnerships in midwifery education. *New Zealand College of Midwives Journal, 24,* April, 7-9.

Pairman, S. & Massey, S. (2001). Where do all the midwives go? A report on the practice choices made by Bachelor of Midwifery graduates. *New Zealand College of Midwives Journal, 25,* October, 16-22.

Pairman, S. (2004). From autonomy and back again. Educating midwives across a century. Paper accepted for publication in two parts in the New Zealand College of Midwives Journal October 2005 and April 2006. This paper was developed from a Keynote address I gave at the NZCOM Biannual National Conference in Wellington in 2004.

Locating the work.

These four pieces all represent works undertaken to explore the importance of midwifery education in the professionalisation of midwifery in New Zealand during the period of study for this Professional Doctorate. Congruent with 'professional doctorate' these works are a result of my professional practice as a midwifery educator and midwifery leader during 1999 to 2005.

As discussed above midwifery education was a central focus for midwives and women in the 1980s and early 1990s as we sought to reclaim midwifery as a profession that was separate to nursing. Whether midwifery was post-basic nursing or not was the key area of contention in disputes about the definition of a midwife and about the location and form of

midwifery education. If midwifery was merely a specialty area of nursing practice then it required prerequisite nursing education and midwifery education should be located alongside the specialist education of other specialty areas of nursing practice. If midwifery was a profession in its own right and a separate discipline to nursing, then it could not rely on entry through nursing but instead required its own education programme to prepare midwives for entry to the profession.

It was largely women (consumers) in New Zealand who gave midwifery a vision of what we could offer women and why we needed our own education system, separate to nursing. Consumer activists sought a return to the more traditional notion of 'midwife'; one who would be alongside women throughout the childbirth experience and who would provide support and guidance from a knowledge base and philosophy that valued and respected childbirth as a normal life event and of which women should be in control. These consumers believed that this kind of midwife could only be prepared through a direct entry midwifery programme and a sub group of the consumer group, Save the Midwife, formed the Direct Entry Midwifery Taskforce to work towards the establishment of direct entry programmes.

In the mid-1980s most midwives did not give priority to establishing direct entry midwifery. The main focus of the Midwives Section at that time was to remove midwifery education from its position as a 'sub-option' within the Advanced Diploma of Nursing and replace it with a one-year tertiary-based midwifery programme.

The shared goal of both women and midwives, however, was to reinstate midwifery autonomy. Without the autonomy that goes with professional status midwives would continue to be constrained in their practice by medicine and nursing, and could do little to provide women with the kind of midwifery care they wanted. Therefore, when women and midwives joined together in shared political activity to bring about midwifery autonomy, they agreed on a strategy to achieve all their goals. Firstly the political energy would go to establishing separate one year courses so that midwifery could begin to influence the education of its new practitioners and a more women-centred philosophy could be

incorporated into education. Next the objective was to achieve midwifery autonomy and from there attention would turn to direct entry midwifery education.

All of these goals were achieved in a very short space of time, although they were actually the result of many years of lobbying by both women and midwives. Separate one-year programmes commenced in 1988 and these were quickly followed in 1992 with the establishment of the first three-year direct entry midwifery programmes. The separate courses closed over the next few years and with recognition of prior learning nurses who wanted to become midwives could complete two years of the direct entry programme to attain midwifery registration.

The key focus of midwifery education is to prepare midwives for midwifery practice who have the knowledge, skills and attitudes necessary for autonomous midwifery practice, but who also embrace midwifery's core values of partnership and women-centred care in their midwifery practice. The challenge for midwifery education has been to ensure the integration of partnership, knowledge and practice in a model of education that reflects the priorities of women and midwives.

I have been involved in these developments in midwifery education from the beginning. Along with Karen Guilliland, I was instrumental in the establishment of the one-year separate midwifery programmes, and I led the development of one of the first three of these programmes in Otago/Southland. Soon after the 1990 Nurses Amendment Act was passed I led the preparation of a direct entry midwifery programme for Otago Polytechnic and our programme was one of two approved to begin in 1992. We offered the first Bachelor of Midwifery programme in New Zealand and (to my knowledge) the first such three year degree internationally. Subsequently I have led the development of a Master in Midwifery programme at Otago Polytechnic and that programme commenced in 2000. From 1997 to 2003, when I stood down because of my appointment to the Midwifery Council, I was the Education Consultant for the New Zealand College of Midwives. Therefore my involvement with midwifery education has been extensive and I have helped lead the transition from workforce to profession through my midwifery education activities.

This portfolio reports a small part of that work. The first piece, the New Zealand College of Midwives National Midwifery Education Framework, was written in 1999 and published in the College Journal in 2000. As described earlier, the College developed this framework over a number of years, and this policy document was written to combine this work into a single framework that would guide the development of midwifery education, particularly in the area of postgraduate education. The College ratified this policy in 1999. This policy now needs to be updated to reflect changes such as the establishment of the Midwifery Council of New Zealand and the Council's refinement of the scope of practice of a midwife.

The second piece is a paper I gave at the International Confederation of Midwives Asia-Pacific Region Conference in Bali in 2000. By drawing on case studies of New Zealand and Ontario, Canada, this paper attempted to demonstrate how midwifery education and midwifery practice are intertwined. Childbearing women, midwifery students, midwife-practitioners, midwife-educators, maternity consumer groups, and the midwifery profession all need to be involved in midwifery education if it is to meet the needs of women and the midwifery profession. This paper draws on midwifery partnership to show the centrality and value placed on various partnerships in midwifery education programmes and how these partnerships contribute to the success and relevance of midwifery education.

The third portfolio piece is a published report of a quantitative study carried out by myself and midwifery student, Sheridan Massey, and funded by a New Zealand Health Research Council summer studentship. The study established baseline descriptive statistics about the practice style and location of practice for graduates from the first two direct entry programmes in New Zealand. Participants were drawn from graduates of Auckland University of Technology (previously AIT) and Otago Polytechnic from 1994 to 1998. It used a survey to gather information about types of employment, locations of employment and reasons for choosing particular practice styles. This research remains the only work to date in New Zealand that explores the practice of direct entry midwives upon graduation. There is need for a more comprehensive and continuous project to explore a number of

midwifery workforce issues in New Zealand, and this has been identified as a priority by the newly established Midwifery Council of New Zealand.

The final piece in this portfolio is a paper drawn from my Keynote address at the New Zealand College of Midwives biennial conference in 2004. This conference celebrated 100 years of midwifery registration and my speech, entitled, 'from autonomy and back again. Educating midwives across a century', discussed the changes in midwifery education from 1904 to 2004. The paper enclosed in this portfolio has now been accepted for publication in the College Journal. Although others have explored aspects of New Zealand midwifery education (Hill, 1982; Papps & Olssen, 1997), this paper is the first attempt to describe all of the major changes in midwifery education since the first St Helen's hospital programmes began in 1905. It is a descriptive historical overview and does not purport to provide in-depth analyses of events in relation to the socio-political context in which they occurred.

These four pieces provide more in depth discussion about aspects of midwifery education as explored earlier. As in previous portfolio pieces, they were written for a specific audience and in a style appropriate to that audience.

Education Framework November 1999

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Introduction

This document provides a framework and guidelines for midwifery education at both pre-registration and post-registration levels. It is acknowledged that this framework will evolve in response to changes in the context of midwifery practice and education in New Zealand. The document will be revised and updated as necessary.

Section One sets out the role of the New Zealand College of Midwives (NZCOM) in relation to midwifery practice and education in New Zealand and the relationship of the NZCOM to other organisations with responsibilities for midwifery education. It also addresses the relationship between midwifery and nursing education in the context of the New Zealand maternity service.

Section Two provides background to the development of this Framework, including the consultation process and discussion of some of the contextual issues that have impacted on the development of this framework.

Section Three sets out the National Framework for Midwifery Education. It provides direction for midwifery educators and educational institutions offering midwifery programmes and represents the consensus view of NZCOM midwife-members throughout New Zealand of the focus they wish to see for midwifery education.

Section One

Introduction

This section describes the role of the New Zealand College of Midwives (NZCOM) in midwifery education. As the professional organisation for midwives in New Zealand, the NZCOM has a legitimate role in providing direction for midwifery education in New Zealand. This direction is set out through this National Framework for Midwifery Education.

Several other organisations also have a role at national level, in influencing midwifery education. The Nursing Council of New Zealand and the New Zealand Qualifications Authority both have legislative authority over approval of programmes and accreditation of educational institutions providing midwifery education. The Clinical Training Agency and the Ministry of Education have complementary roles in the funding of health workforce education in New Zealand. This section discusses the specific role of each of these organisations in midwifery education.

Finally, this section identifies the historical linkage between midwifery and nursing and traces the way in which the recent separation of these two professions in New Zealand has been reflected though changes to their education programmes.

1.1 New Zealand College of Midwives (NZCOM)

The New Zealand College of Midwives (NZCOM) is the recognised professional body for midwives in New Zealand. In honouring the principles of partnership, participation and protection inherent in the Treaty of Waitangi, and in acknowledgement of the essential role of women (as consumers) in midwifery, the NZCOM is founded on the principle of partnership. The partnership between women and midwives is reflected in the organisational structure of the NZCOM, in its Code of Ethics and Standards for Practice[1], in its policy development, in its Standards Review and Resolution Committee processes and in its political activity. Women consumers are members of the College at every level of the organisation. This active involvement of women as consumers within the College has strengthened midwifery at both a political and professional level. It ensures that midwifery continues to uphold the needs and wishes of women and influences the individual practice of midwives to ensure the one-to-one relationships with women are based on equality and negotiation.

Established in April 1989, the College provides a 'voice' for midwives, distinguishing midwifery from other professions with whom midwifery has historically been linked such as nursing and medicine. The College provides professional leadership to all midwives in New Zealand and provides industrial representation to self-employed midwives.

There are ten regions of the College throughout New Zealand, each with a regional chairperson and committee. Each region also has a Standards Review Committee and Resolutions Committee. The regional chair people form the National Committee along with three national consumer representatives, two national representatives from Nga Maia o Aotearoa me te Waipounamu[2], the President, and the National Director. In addition, the National Committee co-opts expertise from the Education Consultant and from the Midwifery Student representatives. Finally, Joan Donley, the College Elder and Mina Timu Timu, Kaumatua to the College, join the National Committee. Together they bring their partnership as Maori and Pakeha Kuia to benefit the College. The National Committee operates on a consensus model, requiring all issues to be fully discussed through the regions before any decisions are made at a national level. Consensus decision-making necessarily involves a lengthy consultation process and the College aims to involve as many members as possible

in this process.

As the professional body for midwifery, the NZCOM has a legitimate role in shaping midwifery education and practice in New Zealand. Education must strengthen the profession, reflect the current context of midwifery practice and maintain a high standard of midwifery practice that meets women's needs. The National Midwifery Education Framework, described in this document, provides direction from the midwifery profession for midwifery education at both a pre-registration and post-registration level. This Framework will provide guidance to midwifery educators, midwifery practitioners and other organisations with a role in midwifery education.

1.2 Relationship with other organisations with a role in midwifery education

1.2.1 Nursing Council of New Zealand (NCNZ)

The regulatory body for Midwifery at present, the Nursing Council of New Zealand (NCNZ) has legislative authority, under the Nurses Act 1977 and Amendments, to approve education facilities and pre-registration programmes for midwives. In this role the Council has set standards for registration of midwives and standards for the educational programmes to prepare midwives. The Council audits these programmes every three years.

Since the passing of the Nurses Amendment Act in August 1990[5], the NZCOM has had the right to nominate one member to the twelve-member Nursing Council. This right ceased when the Health Occupation Registration Amendment Act[4] was passed in October 1999. This legislation reconstituted the membership of the Nursing Council to include three registered nurses, two registered midwives, two members of Nursing or Midwifery educational facilities and four others, one of who can be a midwife and one of who can be a nurse. No professional organisation has the right to nominate the nurse or midwife members and the Minister of Health appoints all members. This new Council will be appointed over a transition year between 1999 and 2000.

Perhaps in recognition of the lack of midwifery representation on Council (one or two in each year), the Council, over the past four years, has entered into collaborative projects with NZCOM over matters of interest to both organisations. In 1996 Council developed its standards and competencies for midwifery registration in partnership with NZCOM[6]. In 1998 NZCOM was well represented on the Nursing Council Working Party that developed the Competency-based Practising Certificate Policy for Registered Midwives[6]. This policy recognises the NZCOM Midwifery Standards Review Process as one mechanism by which midwives demonstrate on-going competency to practice. In 1999 Council passed a policy that determined that entry to the midwifery profession be by Bachelors degree only[7]. This policy is in line with NZCOM policy as outlined in this Midwifery Education Framework. The Nursing Council is now moving to develop policy on post-registration midwifery education and has asked for a copy of the NZCOM Midwifery Education Framework as a starting point for this work[8].

1.2.2 New Zealand Qualifications Authority (NZQA)

Established under the 1989 Education Act, the New Zealand Qualifications Authority (NZQA) has legislative authority to approve undergraduate and postgraduate degree programmes offered within the polytechnic sector, and to accredit the institutions offering these programmes.

Until 1999 all five pre-registration midwifery Bachelor degree programmes were offered through polytechnic educational institutions. In 1999 Massey University amalgamated with Wellington Polytechnic to become the Massey University of Wellington. The New Zealand Vice Chancellor's Committee, through its Committee on University Academic Programmes (CUAP), now takes over the approval of the Bachelor of Midwifery programme previously provided by Wellington Polytechnic[9]. This is the first undergraduate midwifery programme to come under the University system for approval and accreditation.

As the professional body for midwifery in New Zealand, the NZCOM participates in the NZQA approval and accreditation processes for all midwifery programmes. NZQA recognises the legitimate interest of the NZCOM in midwifery education and seeks representation from NZCOM for each midwifery approval panel. The New Zealand Vice Chancellor's Committee approval process does not automatically invite involvement of the appropriate professional organisations and NZCOM will need to seek participation within this process.

1.2.3 Clinical Training Agency

In 1995 the four Regional Health Authorities (RHAs) jointly established the Clinical Training Agency (CTA) to take responsibility for the purchasing of post-entry level clinical training for health professionals. The CTA now performs this same role for the Health Funding Authority (HFA).

The CTA purchases post-entry level clinical training in line with its purchasing priorities and in accordance with certain criteria. These criteria include the following:

- Vocational, rather than academic and research based
- Clinically based, with a substantial clinical component where employment in a clinical setting is integral for completion of the qualification
- Post-entry, which occurs after entry to a health profession, so that a person is eligible to practise in a particular occupation
- Formal programme – trainees are formally enrolled in a training programme which leads to a recognised qualification
- Six months – the formal training programme is to be equivalent to a minimum of six full time months in length.
- Nationally recognised – recognised by the profession and/or health sector and meeting a national health service skill requirement rather than local employer need.[10]

Funding for purchasing of post-entry level education by the CTA came originally from the Government 'unbundling' exercise, where Crown Health Enterprises (CHEs) identified the costs of this clinical training to their budgets. Funding was then transferred from the CHE budgets to the CTA through Vote Health. Initially the CTA rolled over funding to sustain existing post-entry training activities such as medical registrar training. The CTA also discovered that the funding did not cover the cost of the activities.[11] Further unbundling occurred in 1998/9 from a 'deficit switch' of funds from Crown Company Monitoring Agency (CCMAU) to the HFA. This made up to $5 million available to the CTA to support CHE employed registered nurses undertaking clinical training previously funded by CHEs.[12]

Midwifery has not had access to funding from the CTA for post-entry level clinical training programmes. Because of midwifery's historical association as a speciality of nursing, hospitals did not provide post-entry level training programmes for midwives. A large number of hospitals did fund registered nurses to undertake midwifery education, but although this was post-entry training for nurses it provided entry level to midwifery. This funding appears to have been lost within the unbundling exercises.

As midwifery develops its education framework and sets a direction for the future it is necessary to work with hospitals and self-employed midwives to obtain funding for post-entry level education from

the CTA. The nature of midwifery and the recent changes to the maternity services means that many midwives are no longer employed in hospitals and therefore do not fit CTA funding criteria. However, all midwives are still employees of the health system whether they are paid directly by the HFA or through employment contracts with hospitals. The increasing demand of pregnant women for midwifery care is leading midwives to seek opportunities for post-entry level clinical education. The Postgraduate Certificate programme outlined in this Midwifery Education Framework is particularly designed to assist practising midwives to extend and develop their practice skills. Practising midwives need access to CTA funding for these programmes so that they can be accessible to midwives throughout New Zealand.

1.2.4 Ministry of Education

The Ministry of Education funds pre and post-registration midwifery education though its equivalent full-time student (EFT) resourcing system. The Government funds different categories of education, subsidising the cost of education to each student to certain levels. Tertiary students in New Zealand also pay fees towards their education. At the post-entry education level, the Ministry of Education funds programmes that have less than 30% focus on clinical training. The CTA is expected to fund those programmes with more than 30% clinical training. At present the Ministry of Education funds all midwifery education, both pre and post-registration.

1.3 Relationship between midwifery and nursing education

The historical linking of midwifery with nursing education led to the establishment of the one-year separate midwifery programmes within Schools of Nursing at Auckland Institute of Technology (AIT), Waikato, Wellington, Christchurch and Otago Polytechnics between 1989 and 1992 (some of these one-year programmes were preceded by the Advanced Diploma of Midwifery (ADN)/Midwifery option).[15].

Over time, and following the passing of the 1990 Nurses Amendment Act, the recognition of midwifery and nursing as two separate professions began to be articulated through the changing of the names of Nursing departments to Nursing and Midwifery departments. From 1999 several polytechnics began to restructure using the faculty model. Within these institutions midwifery became a separate school within the Faculties of Health[14]. The separation of midwifery from nursing in this way highlights the separate nature of the two disciplines and is a further step in midwifery's aim of self-determination.

The 1990 Nurses Amendment Act demanded a re-evaluation of the role of nurses in maternity services. Over the past nine years the maternity system has changed markedly. Over 60% of pregnant women now receive care from a midwife as their Lead Maternity Carer.[15] Over 80% of pregnant women have a known midwife care for them in labour and birth.[16] The role of the nurse in this system has also changed. Few maternity hospitals now employ nurses. Practice nurses have less involvement in antenatal or postnatal care as most women see their own midwife for this care.

The pre-registration education of nurses has changed to reflect this changed role of nurses in maternity services. Nurses need an understanding of childbirth within the family/social model. They also need to understand the maternity system and how to help pregnant women get the information they require to access the appropriate services. However, the traditional placement of nursing students in maternity hospitals is no longer appropriate or even possible in many areas. This re-evaluation of the nurses role is reflected in the guidance given by the Nursing Council of New Zealand to polytechnics regarding the 'obstetric' component of the comprehensive nursing programme in the May 1999 Handbook for Polytechnics[17]. This states:

Maternal and infant health nursing (previously obstetric nursing)

Registered Comprehensive Nurses must have an understanding of their scope of practice with regard to maternal and infant health. This includes understanding of the legal framework for practice, maternity services available to women and appropriate referral options. In particular, nurses must have knowledge of reproductive/ sexual health, normal fetal development and the physiology of pregnancy, health promotion, the family experience of pregnancy, birth and the postnatal period, infant feeding, normal newborn development and contraception. All students should have some follow-up experience with a family experiencing childbirth. This may take the form of discussion with women and families after birth to explore issues related to new families and postpartum care. Management of maternity care and deviations from the normal are not included in this interpretation.[18]

Summary

This section has discussed the role of the New Zealand College of Midwives in relation to Midwifery practice and education in New Zealand. It has also examined other organisations with a statutory role in midwifery education in New Zealand, and shown the relationships between these organisations and the NZCOM.

The relationship between nursing and midwifery in New Zealand has been examined in light of their relatively recent separation through statute, practice and education.

The next section traces the development of the Midwifery Education Framework in relation to changes in the midwifery profession and maternity service context. This includes documentation of the extensive consultation that occurred amongst midwives in the development of this framework.

Section Two

Introduction

This section traces the developments in midwifery education in New Zealand from the early 1980s to the present day. Alongside these changes the NZCOM has worked through various stages in the development of this Framework for Midwifery Education. Each stage has involved considerable consultation with midwives throughout New Zealand and formal adoption as policy by NZCOM.

2.1 Background

2.1.1 Separating Midwifery from Nursing

The Midwifery Education Framework outlined in this document has evolved since the late 1980's. Midwives began lobbying for changes to their education as soon as midwifery moved from hospital-based programmes to the tertiary education sector in 1979, and was reduced to an option within the Advanced Diploma of Nursing (ADN) programmes. Midwives believed that these programmes provided inadequate preparation for midwifery practice, and each year from 1980 onwards put a remit to the New Zealand Nurses Association (NZNA) annual conference to remove midwifery from the ADN programmes and establish separate midwifery programmes. This remit was finally passed successfully in 1986. By this time other changes were also occurring in midwifery.

The years 1986 to 1990 saw an awakening understanding amongst midwives that their practice could be expanded. The majority of midwives at this time practised in hospitals as part of a fragmented maternity system controlled by medicine. The only midwives practising with a sense of autonomy and understanding of continuity of care were a very small number of domiciliary midwives in the homebirth setting.[19] However, there were some consumers who were aware of what midwifery could offer and they were determined to bring about change. A consumer group, 'Save the Midwives', was established in 1986 to raise awareness of the closure of rural and small maternity

hospitals and to lobby for an autonomous midwife who could provide an alternative to the dominant medical model of maternity care.[20]

A sub-group of Save the Midwives formed the 'Direct Entry Midwifery Taskforce'. Their main objective was to achieve direct entry midwifery. These women believed the system of midwifery training following nursing registration was both inappropriate and a waste of resources. As a profession in its own right, midwifery needed its own education programmes to produce motivated, competent and autonomous midwives.[21] So while midwives fought for separate one-year midwifery programmes for nurses to train as midwives, women challenged midwives to think beyond this to direct-entry midwifery.

The collaborative political activity of these consumer groups in partnership with midwives, culminated in the passage of the Nurses Amendment Act in August 1990. The passing of this statute meant that midwives regained their legal and social mandate for independent practice. The same legislation provided the opportunity for direct entry midwifery education. Section 39 of the Nurses Act 1977 was amended to allow the Nursing Council to approve direct entry midwifery programmes as experimental programmes in tertiary education facilities.[22] By this time separate, one-year midwifery programmes were being offered at three tertiary education institutions, with ADN/Midwifery options available at another two.

The newly formed New Zealand College of Midwives provided a united professional voice to address midwifery education issues. The College utilised much of the work that had begun previously through the Midwives Section of the NZNA. In this forum, midwives throughout New Zealand had contributed to and endorsed the NZNA Midwifery Policy Statement.[23] The request for such a policy arose from the Midwives Section of NZNA and reflected their concern that the previous policy[24] was out of date in light of professional developments and community concerns. An ad hoc committee was established by NZNA to revise and update the 1981 policy. Three, of the five-member committee, were representatives of the Midwives Section. The extensive consultation process that followed included 140 women's groups as well as midwives throughout New Zealand in midwifery's first attempt to involve women in policy development.[25] The resultant policy statement clearly outlined a future for midwifery based on autonomy and continuity of care and a midwifery philosophy of practice. This policy called for discontinuation of the ADN/Midwifery programmes and supported direct entry midwifery education as one route to midwifery registration.

At the same time as the policy statement was being developed, the Midwives Section of NZNA was working on the development of standards. Through an extensive and prolonged consultation process, the Midwives Section reached consensus on a philosophy of midwifery and standards for practice, education and service.[26] These were almost complete when, in 1989, these same midwives disbanded the NZNA Midwives Section and participated in the establishment of the New Zealand College of Midwives. The midwives took their work with them and the philosophy and standards were subsequently adopted by the College, and later reviewed (in both 1992 and 1993) and published within the handbook for practice.[27]

2.1.2 Developing an Education Framework

At the same time as midwifery separated itself from nursing through establishment of the NZCOM and development of a philosophy and standards that articulated midwifery as an autonomous profession, the Direct Entry Midwifery Taskforce was working towards a complete change in midwifery education. The Taskforce, with the assistance of a grant from the McKenzie Trust Foundation, distributed a discussion paper and questionnaire to assess the feasibility of establishing direct entry midwifery education programmes in New Zealand.[28] The 691 replies indicated strong support for direct entry.[29] In February 1990 the Taskforce, in conjunction with Carrington Polytechnic School of Health Studies and with the endorsement of the NZCOM, released a discussion document and draft direct entry midwifery curriculum.[30] 826 copies were distributed directly by the Taskforce and again the responses were positive. Common themes included: the need for input from Maori and other minority groups; the importance of emphasis on quality clinical experience with a focus on the normal and continuity of care; modular structures to enhance distance learning and flexibility; and support for an apprenticeship model of clinical experience.[31]

In August 1990 section 39 of the Nurses Amendment Act paved the way for direct entry midwifery. Section 39 was an experimental clause that required the Nursing Council to inform educational institutions of any amendments necessary to achieve approval if the programme was initially turned down by the Council.[32] Four polytechnics submitted curricula. The Nursing Council approved three initially and the Minister of Health later agreed to fund two programmes, one at Auckland Institute of Technology (AIT) and one at Otago Polytechnic. These programmes were to undergo extensive evaluation before funding would be approved for further programmes elsewhere in New Zealand. Both programmes were three-year programmes but AIT awarded a diploma on completion while Otago developed a Bachelor of Midwifery degree programme.

The debate between degree or diploma programmes occupied the profession in the early 1990s. The Vision 2000 conference held in Auckland in March 1991 was the first opportunity the profession had for national debate on education issues. It resulted in the development of a National Framework for Midwifery Education. This framework was developed by a 'breakaway' group of midwives and consumers when it became clear that the process of development of a nursing and midwifery education framework was not going to meet midwifery's needs.[33] The National Framework for Midwifery Education identified the need for such a framework; recognised the foundation of the Treaty of Waitangi in all aspects of midwifery; identified the implications of professional autonomy on the regulation of midwifery, the role of the College and the pre-registration midwifery education curricula; set out expectations regarding the clinical experience to be offered to pre-registration midwifery students. The degree/diploma debate was identified as an area requiring further discussion by the whole profession.[34]

This debate occurred in each region of the College throughout the remainder of 1991. In February 1992 the NZCOM held an Education Workshop in Wellington, bringing together midwifery educators, practitioners, regional chair people and consumers from throughout New Zealand. A number of workshops were held, one of which further developed the National Framework for Midwifery Education.[35] This Framework proposed that the three-year midwifery pre-registration programmes should be undergraduate degree programmes. It also set out guidelines for post-registration and postgraduate midwifery education through continuing education programmes, masters and doctoral programmes.[36] Following this workshop AIT moved to convert its direct entry diploma programme to a degree programme. Thus all of the first direct entry graduates in New Zealand in 1994 graduated with Bachelors degrees.

This Framework was further refined in May 1994 at the NZCOM National Education Workshop in Palmerston North. Representatives from each region of the College as well as midwifery educators, practitioners and consumers endorsed the 1992 Education Framework and developed a strategic plan to further implement the framework. At this workshop the main issues involved the following:

- Achieving entry to the midwifery profession by undergraduate degree only by 1997;
- Clarifying the relationship between NZQA and NZCOM;
- Developing competency-based practising certificates;
- Removing the experimental status of direct-entry programmes;
- Developing post-registration midwifery education, including obtaining funding;
- Funding clinical experience for pre-registration students;
- Reviewing overseas midwives registration requirements;
- Gaining midwifery representation on relevant education bodies such as the Nursing Council;
- Communicating midwifery education issues within the College.[37]

These decisions were ratified at the NZCOM Annual General Meeting in August 1994.

The years 1994 to 1998 were years of consolidation of midwifery education. Further three-year direct entry degree programmes were commenced at Waikato and Wellington Polytechnics in 1996 and Christchurch Polytechnic in 1997. One-year diploma programmes ceased in Otago (1992), Christchurch (1996), Waikato and Wellington (1998) and in Auckland the last diploma programme is being run in 1999. Postgraduate midwifery programmes commenced at Massey University (1993), Victoria University of Wellington (1994), and at AIT (1999). Otago Polytechnic plans to commence postgraduate midwifery programmes in 2000.

The post-registration midwifery education aspect of the Framework was developed extensively through 1998. In March the NZCOM invited midwifery educators, practitioners, regional chair people, consumers, and representatives of the Nursing Council, Ministry of Health, Ministry of Education, Clinical Training Agency, and Women's Health Managers to a workshop. This workshop developed a draft, post-registration, midwifery education framework and established a small working group to carry on the project. The Framework was developed further at a meeting in April 1998, circulated to all regions of the College and ratified at the Annual General Meeting in Auckland in August 1998. Further detailed work was undertaken at a meeting of the working group in August 1998 and then again in September 1998.

The National Midwifery Education Framework presented in this document combines the earlier work on pre-registration midwifery education with the more recent developments in post-registration midwifery education. The Framework is being circulated to each region for discussion and ratification at the National Committee meeting in November 1999. It brings together all aspects of the Framework for Midwifery Education developed and ratified by the College to date.

Section Three

Introduction

This section outlines the National Midwifery Education Framework and brings together in one document, the work done on an education framework by various midwifery groups between 1990 and the present.

The beliefs of the NZCOM in relation to midwifery education are presented. Each aspect of the programme is described, including the expectation of the NZCOM as to how these programmes will be developed and delivered. A profile of the graduates from each programme is described to demonstrate the linkage, expected by the college, between midwifery practice and education.

3.1 National midwifery education framework

The following framework proposes a pathway from pre-registration programmes that prepare for initial midwifery practice through to continuing education programmes for practising midwives, to postgraduate programmes for those midwives who wish to pursue higher education with a focus on midwifery practice. It is a cohesive framework, and one that the NZCOM hopes to see applied consistently throughout New Zealand by educational institutions offering midwifery programmes.

Underpinning this framework is the recognition by the College that all midwives are expected to work to the NZCOM Standards for Practice and Code of Ethics.[38] In meeting these standards midwives work in partnership with women during the childbirth experience, with each other in practice and with students when facilitating and supervising clinical experience.

The framework offers a series of programmes that build on each other and reflect aspects of midwifery practice. It sets out a variety of midwifery-specific education programmes and identifies the links between them.

Flexible entry and exit points facilitate access for all midwives and enable recognition of the knowledge midwives bring with them from practice, their previous education programmes and their wider life experiences. The framework provides a pathway for midwives planning their on-going education and allows midwives to select routes that meet their specific needs

3.2 Underpinning principles/ assumptions

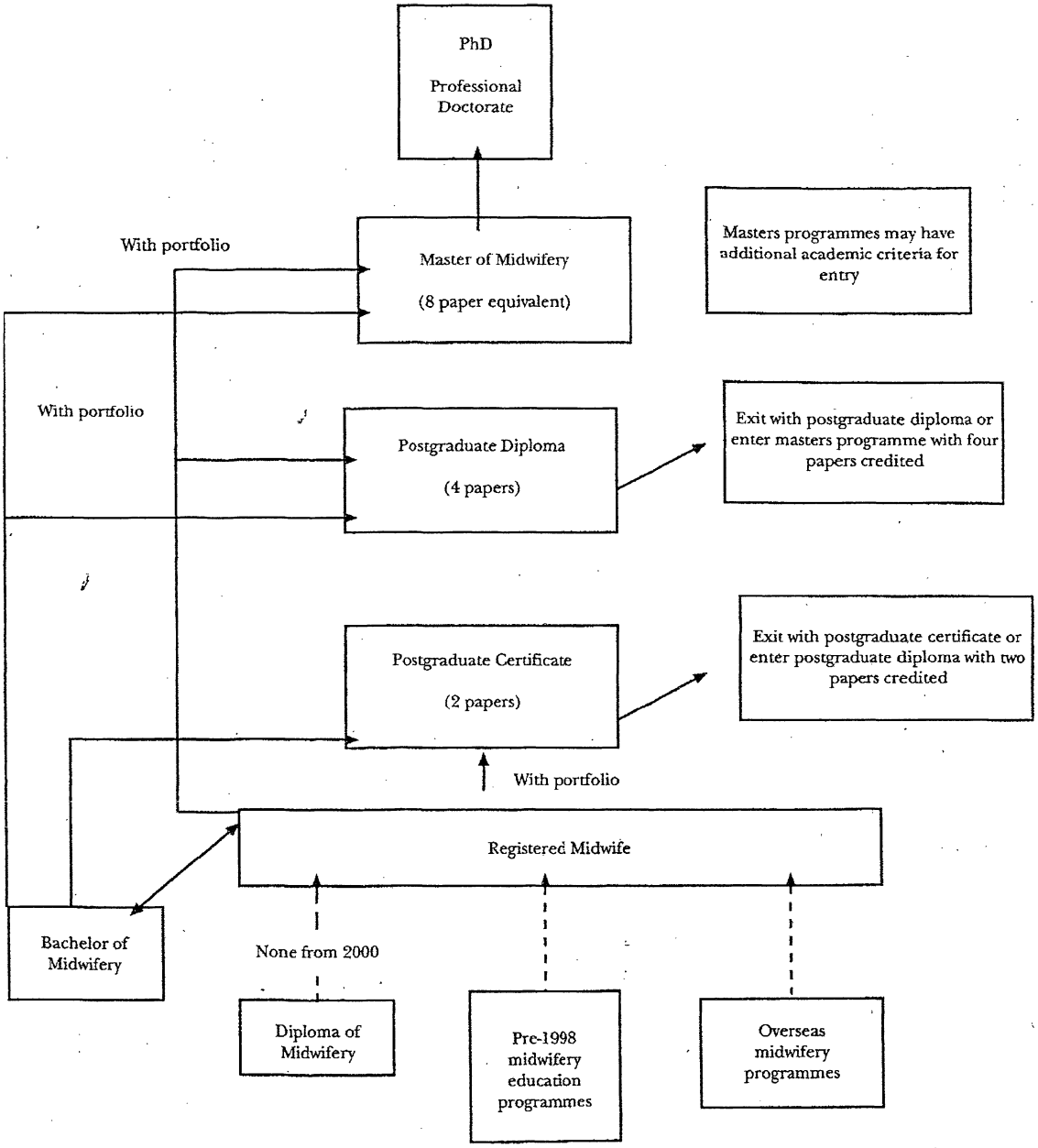
The New Zealand College of Midwives holds certain beliefs about midwifery education. These key assumptions underpin the National Midwifery Education Framework and include beliefs that:

- Midwifery is a profession in its own right and the NZCOM, as the professional body for midwives, has a legitimate role in shaping midwifery education and practice in New Zealand.
- Midwifery is a partnership between the midwife and the woman. This partnership exists within the cultural and political context of New Zealand society.
- The partnership between women and midwives is the strength and base of the profession.
- Midwifery education has its foundation in practice and reflects the centrality of women inherent in the Midwifery Philosophy.
- Midwifery education must reflect midwifery as an independent profession.
- Consumers must be involved in the development and on-going monitoring of all programmes. Curricula must also be developed collaboratively between the educational institution and midwifery practitioners, including representatives of NZCOM.
- Midwifery education programmes should be nationally consistent, with national standards and outcomes, and entry and exit points, but with local development within these standards to meet local needs.
- Midwifery education programmes should articulate with each other and lead to recognised qualifications.
- Midwifery education should be accessible to all midwives.
- Midwifery education programmes should be underpinned by recognition of prior learning (RPL) policies and processes that will enhance flexibility for midwives.
- All midwives are accountable for their practice and for maintaining and updating professional knowledge and skill in midwifery practice.
- Midwifery education is the interaction between students and planned learning experiences facilitated by teachers in a supportive environment.
- The midwifery education environment reflects the principles of partnership, protection and participation as identified in the Treaty of Waitangi.
- Learning is part of the students' wider education, and is the response to their total life experience within and beyond educational settings. Learning is the

Graduate profiles

	Master of Midwifery	Postgraduate Diploma in Midwifery	Postgraduate Certificate in Midwifery	Bachelor Degree in Midwifery
Knowledge	Actively develops midwifery knowledge through research and scholarly enquiry.	Identifies clinical or professional issues requiring investigation and research.	Increases knowledge and understanding with which to assess and manage clinical situations.	Identifies and articulates aspects of discipline-specific knowledge base for midwifery.
	Develops theoretical propositions in relation to midwifery.	Critiques theoretical propositions in relation to midwifery.		
Practice	Acts as a change agent in the provision of midwifery practice.	Continues to develop judgement, discretion and decision-making in midwifery practice.	Uses professional judgement as a reflective and critical practitioner in midwifery practice.	Acquires knowledge and skills necessary for independent midwifery practice.
		Utilises knowledge and skills to deal with uncertainty and change in midwifery practice.	Utilises reflection and self-knowledge to change practice.	Develops professional judgement through critical reflection and practice experiences.
		Participates in development of national clinical guidelines.	Maintains the midwifery focus within a collaborative and interdisciplinary context.	Utilises evidence as a basis for practice and clinical decision-making.
			Develops creative and innovative approaches to midwifery practice.	
Profession	Develops networks at professional, regional, national and international levels.		Actively participates in the midwifery profession at local and national levels.	Actively participates in the midwifery profession at local and national levels.
	Actively participates in the midwifery profession.			
Political	Develops and influences health policy to improve health outcomes for women and babies.	Develops awareness of the impact of broad health policy and directions on midwifery practice.	Participates in development of national clinical practice guidelines.	Critiques and utilises nationally agreed clinical practice guidelines.
Leadership	Takes a leadership role in the midwifery profession.		Provides a positive role model of continuing professional and personal development.	Takes responsibility for own professional development.
			Provides guidance and support for midwifery colleagues and students.	Provides guidance and support for midwifery students.

The Midwifery Education Framework



Continuing education/Midwifery Standards Review
Used as a basis of portfolio applications or recognition of prior learning within programmes

responsibility of the student and is enhanced by sharing experiences, critical reflection, acknowledging cultural differences and beliefs and valuing the contribution of each member to the learning of the group.
- Midwifery curricula reflect the needs of society and of women, particularly in relation to maternity services.
- Women have the right to decide where they will birth and with whom. They have the right to continuity of care from the midwife of their choice.
- As midwives are the only primary health providers who can provide continuity of care during the childbearing cycle, midwifery students must have priority of access to clinical experience with midwives.

3.3 Definition of the Midwife and Scope of Practice of the Midwife.

The New Zealand midwife accepts the World Health Organisation definition of a midwife, as adopted by the International Confederation of Midwives 1972, and the International Federation of Gynaecologists and Obstetricians 1973, which reads:

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

Scope of practice of the midwife

The midwife must be able to give the necessary supervision, care and advice to women prior to, and 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 woman, but also within the family and community. The work should involve pre-conceptual and antenatal education and preparation for parenthood and extends to certain areas of women's health, family planning and childcare. She may practice in any setting including the home, hospital and community.

3.4 Pre-registration Midwifery Education

The focus of the pre-registration midwifery programme is on midwifery as an independent profession that works in partnership with women within the midwifery scope of practice. The overall aim of the programme is to prepare midwives to practice competently and independently in any maternity setting.

Each programme must provide a balanced integration of theory and clinical experience within an environment that promotes critical thinking, reflective practice and the application of research to practice. Clinical experience must encompass continuity of care and independent midwifery practice and each student must have the opportunity to experience homebirth midwifery practice as well as institutionally based secondary midwifery practice.

All pre-registration midwifery education is through a three-year Bachelors degree programme. Each programme must have sound policies and processes for recognition of prior learning so that midwifery students can gain credit and partial exemption for the experiences they bring to midwifery education.

Registered Nurses seeking midwifery registration may receive recognition of those skills and knowledge they hold in common with midwives, through RPL policies applied within the three-year degree programme. As such registered nurses may complete the Bachelors programme within a shortened timeframe.

Entry

Entry into pre-registration midwifery programmes is for direct entry students and registered nurses who wish to move to another profession. The entry criteria should be the same for both groups and include a commitment to women-centered midwifery, maturity and life experience, and the ability to cope with the academic demands of the programme. Midwifery is committed to increasing the numbers of Maori midwives as well as those for other cultural groups. This commitment should be reflected in the entry criteria and selection processes.

Graduate profile

Midwife graduates will be able to:
- Think critically and creatively
- Practice midwifery safely and competently
- Practice autonomously and in partnership with women in any maternity setting
- Utilise research evidence in practice
- Contribute to midwifery's body of knowledge
- Actively participate in the midwifery profession
- Take responsibility for ongoing learning and maintaining competence in practice

3.5 Post-registration midwifery education

A variety of post-registration midwifery education programmes have been developed to meet midwives' specific needs. These programmes recognise that the depth and scope of knowledge on which professional practice is based, develops over time and in different ways. Whilst the College expects all midwives to participate in ongoing learning, each midwife must choose the education programme that best suits her learning needs, practice focus and interests.

3.5.1 Continuing Education Programmes

The Regions of the NZCOM offer continuing education programmes. These are short courses that cater to specific areas of interest and/or enable updating on specific skills such as infant resuscitation or breastfeeding.

Other providers include maternity hospitals that offer in-service education programmes for their midwifery staff.

Such programmes have no formal assessment and cannot award a formal qualification. They may award a certificate of attendance.

Midwives will continue to attend these programmes because of their specific nature. Indeed many midwives will attend these programmes, whilst at the same time participating in more formal ongoing education. While these programmes do not award qualifications, they may be used as evidence of professional development for portfolio applications into formal midwifery programmes or as evidence of continued competency to obtain a practising certificate.

3.5.2 Midwifery Standards Review

Each Region of the College provides a Midwifery Standards Review process. Any midwife-member with a caseload can present for review annually or more frequently if necessary. The review offers the midwife the opportunity to reflect on her practice over the past year with peers and consumers. The review has a supportive and educative focus and emphasises reflective and critical thinking about practice.

This process too, may be used as evidence of professional development for portfolio applications into formal midwifery programmes or as evidence of continued competency to obtain a practising certificate.

3.5.3 Midwifery Bachelor Degree Programmes

Undergraduate midwifery programmes are designed for pre-registration students and now provide the entry level to the midwifery profession. However, this entry level will only been consistent throughout New Zealand from 2000. There are still many registered midwives practising without an undergraduate degree.

Bachelors degree programmes sit at levels 5 (year one), 6 (year two) and 7 (year three) on the National Qualification Framework (NQF). The National Qualification Framework was designed by NZQA to attempt to provide some measure of consistency across education generally. The framework spans level 1 to level 8, with level 8 being all postgraduate programmes including both masters and doctoral programmes.

Utilising the RPL policies of the undergraduate midwifery programmes, registered midwives can be offered one-year midwifery Bachelor degree programmes. These programmes recognise that the registered midwife students have already met the registration requirements. Instead the one-year degree programme focuses on developing degree level skills such as critical thinking and reflection, research skills, academic skills and the development of discipline-specific midwifery knowledge. At level 7 on the NQF, these programmes may be particularly suited to those midwives who do not feel they possess the academic skills necessary for postgraduate study. Indeed, the education previously available to midwives has disadvantaged them in this area. The undergraduate midwifery programme for registered midwives provides a flexible way to acquire these skills while still recognising the extensive knowledge and experiences of these midwives.

The five educational institutions currently approved by the Nursing Council to offer pre-registration midwifery programmes provide undergraduate programmes.[39] These institutions are accredited by NZQA or CUAP to provide degree level education and their programmes have also received NZQA or CUAP approval.

3.5.4 Postgraduate Certificate

The postgraduate certificate provides two papers at level 8 (masters level) on the NQF. The NZCOM expects midwifery educators and practitioners to collaboratively develop these programmes. Accredited educational institutions, that award the qualification, provide the programmes. Teaching within the programmes should be by appropriately qualified educators and practitioners.

The main focus of these programmes is on developing clinical midwifery practice and on providing the basis for further post-graduate study.

Entry is for registered midwives with a Bachelors degree or for midwives with a portfolio that demonstrates their ability to cope with the academic demands of the programme. Midwives should be given clear guidelines by the institution to assist in the preparation of portfolio applications.

Midwives may exit from the programme with a Postgraduate Certificate qualification, or they may choose to continue on into the Postgraduate Diploma programme with credit given for two of the four required papers. Alternatively they may apply for entry into the Masters programme and be credited for two of the eight required papers.

3.5.5 Postgraduate Diploma

The Postgraduate Diploma provides four papers at level 8 (masters level) on the NQF. As for the Postgraduate Certificate, midwifery educators and practitioners develop these programmes collaboratively, with input from the NZCOM and consumers. Accredited educational institutions provide the programmes and award the qualification. Teaching is by appropriately qualified educators and practitioners.

The main aim of these programmes is to expose students to a systematic review of current thinking and research relating to midwifery knowledge and practice and to prepare the student for independent scholarship.

Entry is for registered midwives with a Bachelors degree or portfolio; or for registered midwives with a Postgraduate Certificate. As above, a portfolio application must provide evidence of the midwife's ability to meet the academic requirements of the programme.

Midwives may exit from the programme with a Postgraduate Diploma, or they may choose to continue into the Masters programme with credit given for four of the eight required papers. It is likely that individual educational institutions will require some level of academic achievement for acceptance into the Masters programme. For example, a B grade in one or more papers. The individual institutions will specify these additional criteria.

3.5.6 Master of Midwifery

The Master of Midwifery programme provides eight papers at level 8 of the NQF. Generally there are two types of Masters programmes. The masters by thesis programme consists of four papers plus a four-paper thesis. The masters by papers programme consists of eight papers, of which a minimum of one, but up to three, relates to a research project or dissertation.

Educators, practitioners, consumers and the profession should also develop Masters programmes collaboratively. Accredited educational institutions provide the programmes and award the qualification. Teaching is by appropriately qualified educators and practitioners. Appropriately qualified staff must provide research supervision, with assistance from midwives if the supervisor is not already a midwife.

The main aim of the Masters programme is to provide the student with the opportunity to conduct independent research and scholarship in midwifery and to contribute to the knowledge base of midwifery as a discipline.

Entry is for registered midwives with a Bachelors degree, a Postgraduate Certificate, a Postgraduate Diploma or a portfolio. Individual institutions may have additional academic requirements that must be met for entry.

Exit is with a Master of Midwifery.

3.5.7 Doctor of Philosophy (PhD) / Professional doctorate

Registered midwives with Masters degrees may gain entry into doctoral programmes. There are currently two PhD programmes for midwives in New Zealand offered by accredited Universities that award the qualification. There are currently no Professional Doctorates available for midwives in New Zealand although one has recently begun in Australia.

Both PhD and Professional Doctorate programmes in midwifery focus on research and the development of the knowledge base of midwifery. The PhD usually requires one major research project, while the Professional Doctorate is located in practice and facilitates a number of research projects that directly relate to the practice domain of the midwife.

[1] New Zealand College of Midwives. 1993. Midwives handbook for practice. Dunedin: New Zealand College of Midwives.

[2] Nga Maia o Aotearoa me te Waipounamu is the Maori midwives collective, established to represent the interests of Maori Midwives. The partnership between NZCOM and Nga Maia includes NZCOM financially supporting two representatives from Nga Maia to attend its National Committee meetings.

[3] New Zealand Government. (1990). Nurses Amendment Act. Wellington: Government Printer.

[4] New Zealand Government. (1999). Health Occupation Registration Amendment Act. Wellington: Government Printer.

[5] Nursing Council of New Zealand. 1996. Standards for registration of midwives. Wellington: Nursing Council of New Zealand.

[6] Nursing Council of New Zealand. 1998. Guidelines for competence-based practising certificates for registered midwives. Wellington:

Nursing Council of New Zealand.

[7] Letter from Marion Clark, Chief Executive Officer, Nursing Council to NZCOM, September 1999.

[8] Letter from Marion Clark, CEO Nursing Council of New Zealand to NZCOM, October 1999.

[9] Letter from Dr Ruth Anderson, Academic Director, College of Humanities and Social Sciences, Massey University to NZCOM, September 1999.

[10] Review of the Diploma of Obstetrics and the Diploma of Obstetrics and Medical Gynaecology. A Report commissioned by the Board of the Clinical Training Agency, Christchurch. December 1996.

[11] Committee Advising on Professional Education (CAPE). 1997. Education and Development of the Health and Disability Workforce: recommendations from CAPE's consultation with health, disability and education sectors, September.

[12] Letter from Winston McKean, Director CTA, to various nursing groups, 10 June , 1998.

[13] AIT, Waikato, Wellington and Christchurch Polytechnics all offered ADN/Midwifery options from 1979 when all nursing and midwifery education transferred into the tertiary education sector. Separate one-year midwifery programmes were approved in 1987 to commence in 1989. This was the result of extensive lobbying by the Midwives Section of NZNA and followed the release of the Department of Education (1987) report, Evaluation of the Advanced Diploma in Nursing Courses. The Working party on Midwifery, Short Courses and Related Courses was established in 1987 to make recommendations on the phasing in of these programmes, and in 1989 AIT, Wellington and Otago/Southland Polytechnics commenced one-year midwifery programmes. Waikato and Christchurch were required to continue offering the ADN/ Midwifery option to provide control groups for the evaluation process. In the event student demand led to Waikato then Christchurch ceasing the ADN/Midwifery programme by 1991 and commencing one-year separate programmes in 1992. The Ministry of education review was not completed, as there was no market for the ADN/Midwifery option.

[14] Christchurch Polytechnic and Otago Polytechnic.

[15] North Health Regional Health Authority. (1997). Joint Regional Health Authority Maternity Project. Auckland: Author.

[16] Guilliland, K. (1998). A demographic profile of self-employed (independent) midwives in New Zealand. Unpublished masters thesis. Victoria University of Wellington.

[17] Nursing Council of New Zealand. May 1999. Nursing Department/Schools Handbook: for Tertiary Education Institutions offering Pre-registration Nursing programmes. Wellington: Nursing Council of New Zealand.

[18] Ibid p. 12.

[19] Donley, J. 1986 Save the midwife. Auckland: New Women's Press.

[20] Strid, J. 1987. Maternity in revolt. Broadsheet, 153, 14-17.

[21] Strid, J. 1988. Midwifery education for the future: a joint decision. Save the Midwives Newsletter, 15, May, p.1.

[22] Donley, J. 1990. Autonomy for Midwives. New Zealand College of Midwives Journal, November, p.7.

[23] New Zealand Nurses' Association Inc. 1989. Midwifery Policy Statement. Wellington: New Zealand Nurses' Association.

[24] New Zealand Nurses Association Inc. 1981. Policy Statement on Maternal and Infant Nursing. Wellington: NZNA.

[25] Bickley, J. 1989. Attempting to involve consumers in midwifery policy development. New Zealand College of Midwives Journal, 1st issue, 11-13.

[26] New Zealand College of Midwives. 1990. Standards for Midwifery Practice. Service and Education. Dunedin: NZCOM.

[27] New Zealand College of Midwives. 1993. Midwives Handbook for Practice. Dunedin: New Zealand College of Midwives.

[28] Jill White Eyres. 1988. Direct entry midwifery: the education of the future. Save the Midwives Newsletter, 15, May, 24-26.

[29] New Zealand College of Midwives. 1990. Direct entry midwifery update. Newsletter, 2, (5), February, p.11.

[30] Save the Midwives Direct Entry Midwifery Taskforce. 1990. Direct entry to midwifery. Save the Midwives Newsletter, 23, May, 12-20.

[31] Ibid.

[32] Judi Strid. 1991. The need for ongoing discussion and debate. Maternity Action & Save the Midwives Newsletter, 26, Autumn, p.1.

[33] Pairman, S. 1991. A framework for midwifery education. New Zealand College of Midwives Journal, May, 7-9.

[34] Ibid.

[35] New Zealand College of Midwives. 1992. A framework for Midwifery Education. Report on Education Workshop, February 1992, Wellington, Christchurch: NZCOM.

[36] Ibid.

[37] New Zealand College of Midwives. 1994. Education Workshop Discussion Papers, Palmerston North, May 1994. Christchurch: NZCOM.

[38] New Zealand College of Midwives. 1993. Midwives Handbook for Practice. Dunedin: New Zealand College of Midwives.

[39] AIT, Waikato, Wellington, Christchurch and Otago Polytechnics.

International trends and partnerships in midwifery education

Adapted from a paper presented at the International Confederation of Midwives Asia-Pacific Region Conference - Bali, October 20

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Introduction

Midwifery practice and midwifery education are inextricably intertwined. To prepare the midwife of the future it is necessary to offer her an education that provides her with the knowledge and skills necessary to practice safely and effectively. To do this it is essential that the student midwife can work alongside more experienced midwives who work in the model that she is being taught. Practising midwives are the most influential role models for students, and thus must understand and believe in the model of midwifery that the student is being taught. Changes can be made to maternity systems in countries through legislation, but the most significant change comes from socialisation of midwives and women to a new way of looking at maternity systems. When women and midwives start to do things differently, society as a whole begins to change and the dominant values of the maternity services can begin to change.

In this paper I intend to explore several strategies for ensuring congruence between pre-registration midwifery education and midwifery practice with reference to New Zealand and Ontario, Canada. Both countries have experienced resurgence in autonomous midwifery over the last ten years and have developed midwifery education programmes that reflect this midwifery autonomy. Interestingly, both New Zealand and Canada offer models of midwifery practice and education that differ significantly from their nearest neighbours, Australia and America respectively. And both countries offer models of midwifery that are highly successful with good outcomes for mothers and babies, and cost effective maternity services. I believe that the models of midwifery practice and midwifery education that operate in New Zealand and Canada contribute significantly to the midwifery success each has experienced. The international midwifery community can learn from their experiences.

Setting the scene: New Zealand

New Zealand has had a regulated midwifery workforce since 1904 but over the last 100 years the scope of practice of these midwives changed significantly as a result of increasing hospitalisation and medicalisation of childbirth. From autonomous practitioners working within the full scope of practice in the early 1900's, midwives gradually become 'assistants' to doctors. From working in the community midwives began working mostly in hospitals and within specific areas such as antenatal clinic, labour ward or the postnatal ward, as pregnancy and childbirth became fragmented into specialised and separate parts of the whole. In this process midwives lost their understanding of childbirth as a normal life event and of themselves as 'guardians' of the normal. Instead they experienced highly interventionist and medicalised maternity care where the doctor and the hospital directed the process (Donley, 1986).

This is a model that will be familiar to many midwives. It was this model, dominant through the 1920's to the 1980's that was imposed by Western countries such as New Zealand, Australia, Britain and America on our neighbours in the Pacific, Asia, Africa and the Americas, in our attempts to help 'improve' and westernise the maternity services in many countries and to decrease maternal and infant mortality and morbidity. Some countries have been left with this legacy and for many it has not been a successful strategy.

In New Zealand, however, it was women who rebelled against this model of childbirth and demanded the return of the 'traditional' midwife – one who would be alongside them throughout the whole experience from pregnancy through to six weeks after the birth of the baby. They wanted midwives who would believe in their abilities to give birth without medical intervention and who would support them to reclaim childbirth as a normal life event. New Zealand women wanted to take back the control of their birthing experiences and take their rightful place at the centre of events instead of the central control of medicine (Donley, 1989).

In the1980s midwives joined with women in this campaign to reinstate midwifery autonomy and together, in partnership, they carried out a very successful political strategy that culminated with legislation that secured the professional autonomy of midwives. The model of midwifery that has developed in the decade since that legislation is one of partnership between the midwife and the woman. The majority of New Zealand midwives now choose to work as independent practitioners carrying their own caseload of clients with responsibility for all their care within the normal scope of practice.

Over the last ten years the maternity services have changed dramatically. For example, 86% of women received care from a midwife throughout pregnancy, birth and the postnatal period in 1999, whereas previously continuity of care was only available in a limited way for those few women who chose homebirths. Now, instead of doctor-led care being the only option, some 71% of women choose midwifery-led care and this figure is still increasing rapidly (New Zealand Health Information Service, 2000). Now, instead of doctor controlled maternity services, women expect, and are legally entitled to, information and the right to make informed decisions about their care. Now, instead of hospitals serving the needs of the health professionals there is an expectation of women-centered maternity services. New Zealand society is regaining its understanding of childbirth as a normal life event and the midwife is once again being seen as the primary practitioner in normal childbirth services.

Midwifery Partnership

The midwifery model that underpins the New Zealand maternity services is one of partnership between the midwife and the woman (Guilliland & Pairman, 1995). This is a relationship of equity to which both make equally valuable contributions. The midwife brings her knowledge, skills and experience and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth. Fundamental to partnership is communication and negotiation (Pairman, 1998). Over the period of the pregnancy the woman and the midwife get to know each other and to trust each other. They talk about their expectations of each other, they talk about how the pregnancy is progressing, they talk about options for care and decisions the woman will need to make. The midwife offers information and the woman is supported to make informed decisions about her care. Nothing is done to the woman without her permission and without having discussed it first. The woman remains in control of her birthing experience, making decisions about how she wants it to be. The midwife stands alongside the woman in a supportive role. She guides

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the woman and supports her decisions but does not take control. The power balance between them is equal and they share responsibility for what happens and for the decisions they make. The midwife aims to help each woman to reach her full potential and to have a positive, safe and fulfilling experience. Midwives believe that if women have this kind of positive birthing experience, that they will have more confidence in themselves as mothers and that this, in turn, will have a positive effect on children, on families and on society at large. For both the woman and the midwife the notion of partnership assumes their autonomy, their ability and their right to make decisions together, and their ability and right to take responsibility for those decisions (Pairman, 1998). Partnership involves a shift of power from the doctor or midwife to the woman and the midwife's allegiance moves from the doctor to the woman as she supports her and stands alongside her.

This midwife: woman partnership is now the basis for midwifery services in New Zealand. However, this partnership model extends beyond the individual midwife: woman relationship to the professional organisation that works in partnership with consumer groups at a political and professional level. It also extends into education where this partnership model underpins the pre-registration midwifery education programmes in New Zealand. For New Zealand midwives partnership with women defines their professional status (Guilliland & Pairman, 1995). I will come back to partnership but first I want to turn to Canada.

Setting the scene: Ontario, Canada

Ontario was the first province in Canada to regulate midwifery after a long history of illegal midwifery that had led to an increase in lay midwives and underground midwifery practice. Like New Zealand it was women who demanded a change and a strong consumer movement brought about legislation that legalised midwifery and created a new midwifery profession. Unlike New Zealand, Ontario had the opportunity to develop a midwifery profession from scratch and they drew on the experiences of Holland and Britain for this new midwifery model.

The model of midwifery that has developed in Ontario is based on the ICM definition of a midwife as an autonomous practitioner within the realms of normal childbirth. Midwives are based in the community in group practices and one or two midwives, who work together, care for each woman. Midwives have access to maternity hospitals and women have the choice of homebirth or hospital birth (Kaufman, 1991).

Ontario does not claim 'partnership' as a concept that is central to midwifery practice although a number of concepts are shared between the two models. For example both New Zealand and Ontario offer a one-to-one midwife: woman relationship, continuity of care, informed choice and consent, autonomous midwifery practice and a focus on the normalcy of pregnancy and childbirth (Interim Regulatory Council on Midwifery, 1991). Likewise the model of pre-registration midwifery education offered in Canada is very similar to that in New Zealand and draws on several aspects of the partnership model.

Midwifery education: partnership in action

In developing a new midwifery profession both New Zealand and Ontario have developed a new system for preparing midwives for registration. Both started with deciding what it was that midwives needed to do within their maternity services and claiming this scope of practice as unique to midwives. For both, as I have explained, the scope of midwifery practice is in line with the ICM definition. That is, midwives work autonomously within the scope of normal childbirth or primary maternity services. Midwives work in consultation with an obstetrician when complications arise and the woman or her baby requires assistance from secondary maternity services. Midwives in both countries care for women at home and in maternity hospitals and are able to access the facilities without necessarily being employed by hospitals.

Direct-entry midwifery

Both New Zealand and Ontario chose three-year direct-entry midwifery programmes to prepare new midwives. New Zealand had a history of nurse-midwifery where registered nurses could complete further education to become midwives but Ontario did not. However, in both countries women were concerned that to successfully prepare midwives who could work autonomously and who would support women to take control of childbirth, it was necessary to educate women who had not previously been socialised in a health system that places power and control with medicine. Thus, while nurses could still undertake midwifery education programmes, it was considered important that the majority of midwives be direct-entry. Any nurses who were accepted into midwifery completed the same education programme as direct entry midwifery students, although they may obtain credits for some aspects of the programme.

Combining theoretical learning with apprenticeship learning

Both education models deliberately take the best of other international education models. Significant teaching occurs in the classroom within an educational institution. This focuses on ensuring a sound theoretical base that seeks to produce midwives who can articulate their own philosophy of practice, utilise research in their practice and think critically about practice. Linked with this theoretical learning is apprenticeship learning where students work alongside a practising midwife on a one-to-one basis for long periods of time. The midwife provides an important role model for the student's learning. Unlike traditional apprenticeship models, however, the student works with more than one midwife through the programme and in this way is exposed to several ways of practising. Students learn, not only from the positive practice they see, but also from the practice they choose not to emulate in the future.

Partnerships in action

Within these education programmes a variety of partnership relationships exist, through which the student learns about how to practice in partnership with a woman. These partnerships all involve continuity of care so that the relationships have time to develop trust and understanding for each partner. These partnerships include the following:

Woman: Student Midwife partnership

Each student is allocated a number of women to 'follow-though' over the course of the three-year programme. The student is expected to get to know the woman, to accompany her through her pregnancy and birth experience from early pregnancy to six weeks postpartum. The amount of 'hands on' involvement the student will have depends on her stage in the programme and has to be negotiated with the woman as well as the other providers such as the midwife. In this way the student and the woman develop their own partnership relationship and have to negotiate how the student will be involved in the process. The student is able to learn about childbirth from the perspective of the woman as well as her own, and to begin to understand the importance of communication, trust, time, power sharing and negotiation to the partnership relationship. The learning that students achieve from women is most

powerful and stays with them throughout their careers.

Student Midwife: Midwife partnership

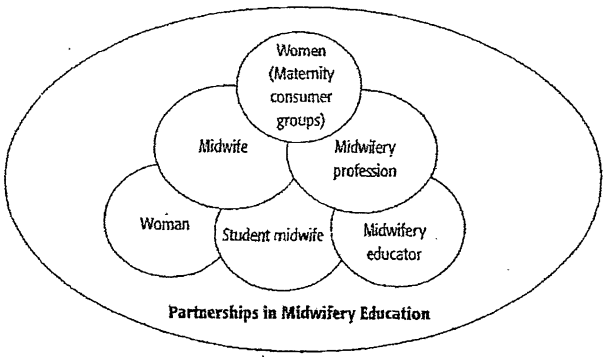
As well as having 'follow-through' experiences with women, midwifery students are also allocated to work with midwives on a one-to-one basis throughout the course. The length of time of these placements increases as the student goes through the programme, so that by the third year the student has the opportunity to really demonstrate her competence and developing confidence as an autonomous midwife. The midwife provides a really important role model for the student in integrating the knowledge and skills gained in the classroom with real practice. She supports and guides the student, allowing her to practise and develop her own style while keeping the woman safe and ensuring that high practice standards are maintained. The midwife needs to be open to student questioning and able to explain clearly about her practice and why she has done what she has done. Again the learning students experience with midwives is powerful and 'real'. The more congruence there can be between the classroom teaching and this real world of practice, the more influential the midwife's teaching will be.

Student Midwife: Midwife-Teacher partnership

Within the classroom it is also important that students are exposed to positive midwife role models. Midwifery teachers need to have high levels of knowledge and be able to share knowledge with students that is up to date, research based, challenging and relevant to practice. Midwifery teachers need to be credible with their professional colleagues as well as students and should maintain some level of midwifery practice alongside their teaching. Ontario has formalised this aspect, and requires all midwifery teachers to carry a small caseload of clients for whom they provide independent midwifery care throughout the year. Thus teachers can work alongside students in practice as well as in the classroom, reinforcing practice and providing a safe environment for students to debrief and question. Midwifery teachers have an important function as resource people for students, guiding the students learning and challenging their thinking.

Midwife-Teacher: Midwife partnership

The success of any midwifery education programme relies on the integration of theoretical teaching with practice. By developing strategies that require students to have long placements with midwives in practice as well as requiring midwifery teachers to maintain current practice, these education programmes acknowledge the fundamental partnership between the educators and the practitioners. Neither can provide enough on their own and it is the alliance of the two that will determine how successful the programme is. Both midwives and educators must be involved in the development of curricula and the planning of the programmes. Both must be aware of the objectives of the various aspects of the programme and the expected achievement of the student. Both must be involved in assessment of the student. In both New Zealand and Ontario this partnership has meant ongoing professional development programmes to help support registered midwives to update their knowledge and skills necessary for this new scope of practice. It has also meant developing programmes to help midwives learn the skills of mentoring and teaching so that they can work effectively with students.



Midwifery Programme: Midwifery Profession partnership

As stated earlier, the midwifery education programme of a country must reflect the kind of midwife the midwifery profession wants to produce. An important partnership exists between the profession and the providers of the midwifery education programme to ensure that the programme meets the standards and aims of the profession. The profession defines the scope of practice and the expected standards for midwives and should be involved in curricula development and the ongoing monitoring of the programmes.

Midwifery Programme: Women partnership

In the end it is the kind of midwife that women want and need that is most important. This can occur through involvement of maternity consumer groups in the development of curricula, in the ongoing monitoring of the programme and in the assessment of students so that they can influence the kind of midwife that is produced through the midwifery education programme.

Thus you can see that the model of midwifery education chosen by New Zealand and by Ontario is inextricably linked to the maternity service it is part of. A series of intertwined circles represent the various partnerships that are integral to the development and maintenance of these programmes. These partnerships keep the programme grounded in what is its primary aim – to produce midwives who are capable of working autonomously as primary maternity care providers within their countries, and within this – to produce midwives who can work in partnership with women.

New Zealand and Ontario midwives have succeeded in revitalising midwifery in both their countries, raising both the status of midwifery and the status of women. The congruence between the midwifery education programmes and the scope of practice of the midwives is an important part of this success.

References

Donley J. (1986). Save the midwife. Auckland: New Women's Press.

Donley J. (1989). Professionalism. The importance of consumer control over childbirth. New Zealand College of Midwives Journal, September, 6-7.

Guilkland, K. & Pairman, S. (1995). The Midwifery partnership: a model for practice. Monograph Series 95/1. Department of Nursing and Midwifery, Victoria University of Wellington.

Interim Regulatory Council on Midwifery. (1991). Midwifery in Ontario. Questions and Answers – information pamphlet. Toronto: Authors.

Kaufman, K. (1991). The implementation of midwifery in Ontario. Ontario Medical Review, November, 9-11.

New Zealand Health Information Service. (2000). National Minimum Data Set. Wellington: Ministry of Health.

Pairman, S. (1998). The Midwifery Partnership: an exploration of the midwife/woman relationship. Unpublished Masters Thesis, Victoria University of Wellington, New Zealand.

Where do all the midwives go?

A report on the practice choices made by Bachelor of Midwifery graduates

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Introduction

Direct entry midwifery education has been available in New Zealand since 1992 when it was reintroduced as an 'experimental' programme following the 1990 Nurses Amendment Act. Five schools of midwifery (Auckland University of Technology, Waikato Polytechnic, Massey University in Wellington and Palmerston North, Christchurch Polytechnic Institute of Technology and Otago Polytechnic in Dunedin) now offer pre-registration midwifery programmes for both direct-entry and registered nurse students. All programmes are required to produce midwives who are capable of independent (autonomous) midwifery practice and able to take on the role of Lead Maternity Carer (LMC) within the New Zealand maternity services (Nursing Council of New Zealand, 1996).

Despite the evaluation and monitoring of these programmes that has occurred, graduates have not been followed up to discover whether they do in fact work independently after graduation.

This project aimed to begin this work by tracking all direct entry midwifery graduates from Auckland Institute of Technology (AIT; now Auckland University of Technology) and Otago Polytechnic between 1994 and 1998. It set out to trace their work histories as midwives and identify the major influences on the choices each made in this regard.

Background

The collaborative political activity of many consumer groups in partnership with midwives, culminated in the passage of the Nurses Amendment Act in August 1990. The passing of this statute meant that midwives regained their legal and social mandate for independent practice. Thanks to strong lobbying from consumer groups such as 'Save the Midwife' and the 'Direct Entry Midwifery Taskforce' the same legislation also provided the opportunity for direct entry midwifery education. Section 39 of the Nurses Act 1977 was amended to allow the Nursing Council to approve direct entry midwifery programmes as experimental programmes in tertiary education facilities (Donley, 1990). Approval was given for two pilot programmes, one at AIT and one at Otago Polytechnic. Both programmes commenced in 1992 as three-year programmes, but Otago Polytechnic offered a Bachelor degree programme while AIT offered a diploma programme. Two years later AIT converted their programme to a degree, thus all of the first direct entry graduates in 1994 graduated with Bachelor degrees.

The programmes were monitored and audited closely over the first four years through a research team established jointly by the Departments of Health and Education. This monitoring found no reason for concern and graduates were found to be as safe and competent as their nurse-midwife colleagues (Harris, 1995). In 1996 further programmes commenced at polytechnics in Waikato and Wellington, and a year later in Christchurch. The three year Bachelor of Midwifery programme is now the recognised route to midwifery registration for all midwifery students in New Zealand, both direct entry and registered nurses (Nursing Council of New Zealand, 2000).

The programmes provide balanced integration of theory and practice within a context that supports and promotes critical thinking, research-based practice and reflective practice. Clinical experience focuses on continuity of care and independent practice and each student must have the opportunity to experience both community-based and institutional-based midwifery practice (Nursing Council of New Zealand, 2000).

The New Zealand College of Midwives (cited in Pairman, 2000, p.12) expects that midwifery graduates will be able to:

- Think critically and creatively
- Practice midwifery safely and competently
- Practice autonomously and in partnership with women in any maternity setting
- Utilise research evidence in practice
- Contribute to midwifery's body of knowledge
- Actively participate in the midwifery profession
- Take responsibility for ongoing learning and maintaining competence in practice

There has been no national study to follow up the graduates from any direct entry midwifery programmes.

In the years from 1992 to the present, much work has gone on within the programmes and within the profession to develop and 'fine tune' these programmes to ensure that these outcomes are met. Despite this attention to programme development, there has been no national study to follow-up the graduates from any direct entry midwifery programmes to look at outcomes of the programmes.

This project began that work through the examination of the work histories of graduates from the AIT and Otago Polytechnic Bachelor of Midwifery programmes between 1994 and 1998. The project sought to discover where and how these midwife-graduates have chosen to practice after graduation and the main reasons for these choices.

Literature review

Direct-entry midwifery education is being debated and implemented in many countries in the western world. The Netherlands has increased the length of its programme while direct entry midwifery education has been reintroduced in the United Kingdom (Megavand, 1998; English National Board (ENB), 1997). In countries such as Canada and Australia programmes are now being established. For all these countries the impetus for direct entry midwifery stems from a need to prepare midwives who can work in the full tradition of autonomous practice (MacKeith, 1995; Megavand, 1998; Tyson, 2000; Australian College of Midwives, 1999). Autonomous midwifery is seen as an essential strategy in changing the maternity services in these countries to more women-centred models.

Despite the increase in direct entry midwifery education programmes, only three evaluations of direct entry midwifery education programmes have been reported in the literature. Kent, Mackeith and Maggs (1994) evaluated the implementation of direct entry midwifery education in England. A study, commissioned by the English National Board for Nursing, Midwifery and Health Visiting, evaluated the effectiveness of the outcomes of pre-registration midwifery education programmes (ENB, 1997). In New Zealand a small working group consisting of representatives of the Ministry of Health, Ministry of Education and Nursing Council of New Zealand extensively evaluated the first two direct entry midwifery programmes in New Zealand (Ernst & Young, 1993a;

Ernst & Young, 1993b; Harris, 1995). While there are aspects in all three studies that are of interest in relation to programme development, none focuses in detail on where the direct entry graduates go to work or why they make these choices.

Design

This research project was a quantitative study that sought to establish baseline descriptive statistics about the practice style and location of direct entry Bachelor of Midwifery graduates in New Zealand. Ethical approval was obtained from Otago Polytechnic Ethics Committee.

Sample

The group to be surveyed was restricted to graduates from direct entry midwifery programmes at AIT and Otago Polytechnic, as these two programmes had been running the longest and thus provided a greater opportunity to track changes over time. Only graduates who had no prior nursing qualification were sent a questionnaire package in order to increase the homogeneity of the group. A total of 144 graduates were sent a questionnaire – 77 from AIT and 67 from Otago Polytechnic. 94 questionnaires were returned constituting a total return rate of 65.2%. AIT graduates returned 47 questionnaires (59.7%). Otago Polytechnic graduates returned 48 questionnaires (71.6%). All participants were female.

Data Collection Tool

As no previous study had examined the employment patterns of direct entry midwifery graduates in New Zealand, it was necessary to develop a questionnaire specific to this study. The questionnaire was pre-tested by 6 midwives. The final questionnaire consisted of ninety-three questions and took about 15 minutes to complete.

The questionnaire began with the title, consent statement and a brief synopsis titled 'Frequently Asked Questions' (FAQ). The FAQ outlined what respondents could expect in the questionnaire, and anticipated respondents' queries about the rationale behind questions and how they should go about answering them.

The main body of the questionnaire had four sections beginning with 'Part A – Demographics'. Eight questions were asked to collect details of age, marital status, dependent children, ethnic group, institution of graduation, year of graduation, year of registration as a midwife and whether respondents had practised as a midwife since registration.

Section B – Description of Midwifery Practice sought information about each position the respondent had held as a midwife since graduation. Questions related to when, where and why the position was taken as well as the employer, hours, practice style and caseload (if any) involved in the position.

Section C – Continuity of Practice sought information about any breaks (other than holidays) that respondents may have taken from practising midwifery.

Section D – Other Career Choices gathered information only from respondents who had not practised as a midwife since graduation about their alternative career choice.

Section E – Plans for future practice brought the questionnaire to its conclusion. These questions related to where respondents were headed in the future and allowed for comparison between respondents' practice at the time of the survey and their intentions for future practice.

Method

A list of all 144 graduates from the two three-year midwifery programmes at Otago Polytechnic and AIT was compiled using graduation lists and registration details available in the public domain. Contact addresses for graduates from both programmes were found through the electoral rolls, telephone directory, advertisements and peer and

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personal contact elicited by an advertisement placed in the NZCOM Journal. The graduates were sent an information sheet and questionnaire by mail and were invited to participate by completing and returning the questionnaire.

Graduates were informed that by returning the questionnaire they had understood the information sheet and given consent to taking part in the study. A 'reminder' letter was sent to non-respondents when the response rate reached 50%. Letters and questionnaires were given to the Nursing Council of New Zealand (Nursing Council) to post on our behalf, for a small number of graduates whose addresses could not be confirmed without access to the registration database. Contact details were kept separate from questionnaires at all times to ensure the anonymity of respondents. Data was refined using Microsoft Excel and analysed using 'Statistical Packages for Social Science 9.0 for Windows' (SPSS).

Results

All the data analysed was nominal. Mode, skewness and range were used to measure distribution and the chi square test was used to measure relatedness (α=0.05 or 0.01).

Demographics: with the exception of 'Ethnic group', the distributions of all demographic details were normal (skewness <+/- 1.00). When compared to national figures on women over the age of twenty in the work force, respondents were more likely to be over thirty years of age (χ^2=4.6, df=1, α=0.05) (Department of Statistics, 1992). This difference disappeared when looking specifically at women employed as Life Science and Health Professionals (χ^2=0.96., df=1, α=0.05) (Department of Statistics, 1992). Compared to national figures for women in the workforce, respondents were also more likely to be married or in a marriage-like relationship (Department of Statistics, 1992). Some 5.5% (n=5) of respondents identified their ethnicity as Maori. New Zealand graduates are significantly older than their counterparts in the UK (χ^2=22.5, df=1, α=0.01) (ENB, 1997).

Regions: Most respondents remained in the regions surrounding the institution from which they graduated. No respondent took up an initial position outside of New Zealand and they tended not to move between regions once they had obtained a position. Otago graduates were more likely to take positions in a wider variety of regions (χ2=115.6, df=10, α=0.01) (see Figure 1).

Practicing in a rural/urban/combination area: The majority of positions taken up were in an urban setting (69.5%) and respondents from AIT were more likely to be working in an urban area than respondents from Otago. (χ^2=7.8, df=2, α=0.05). Respondents working in rural settings were more likely to be carrying their own caseload (χ^2=20.1, df=2, α=0.01).

Figure 1: Percentage of respondents who remained in the region in which they studied

	1994	1995	1996	1997	1998
AIT	4/8 = 50%	9/10 = 90%	9/10 = 90%	5/8 = 60%	9/9 = 100%
Otago Polytechnic	5/10 = 50%	9/10 = 90%	4/10 = 40%	5/9 = 60%	4/8 = 50%

Employment category: When looking at all positions taken up, most were in a hospital setting (61.2%); this was followed by those in self-employment claiming from the national maternity funding schedule, known as Section 51 (26.1%). However, employment category did not determine the type of practice with respondents taking on a variety of roles in both settings (see Figure 2). Across all positions 45.8% of respondents were caseloading, 51.6% worked in core facility positions and 2.6% worked in other positions such as management, education and casual postnatal.

Figure 2: Comparison of employment categories and settings

Core facility midwives	46.3%
Caseloading midwives	43.5%
Multi-role in small units	1%
Midwifery management	0.5%
Self employment	26.1%
Employed by a public hospital	15.2%
Working under a contract outside Section 51	2.1%
Working for a tertiary education institution	1%
Subcontracted to an independent midwife	0.5%

Trends in practice style: In the first position, respondents from Otago were more likely to be caseloading than those from AIT (χ^2=8.1, df=1, α=0.01). However, in their current positions this difference between AIT & Otago disappeared. The overall trend was toward caseloading for both groups of respondents (χ^2=12.1, df=1, α=0.01).

Reasons for taking up positions: In the first position, for all graduates, practice style was the most frequently occurring reason for taking up the position (see Figure 3). Respondents who were self-employed were more likely to indicate practice style (49.5%) than any other reason for taking up a position. While practice style continued to dominate (32.3%), respondents employed in a hospital setting were more likely to indicate that they were also influenced by issues related to 'finances' (25.85%), 'family' (20.4%) and 'compromise / expedience' (22.6%). In the hospital setting, specific reasons for taking up a position differed between core facility and case loading respondents (see Figure 4).

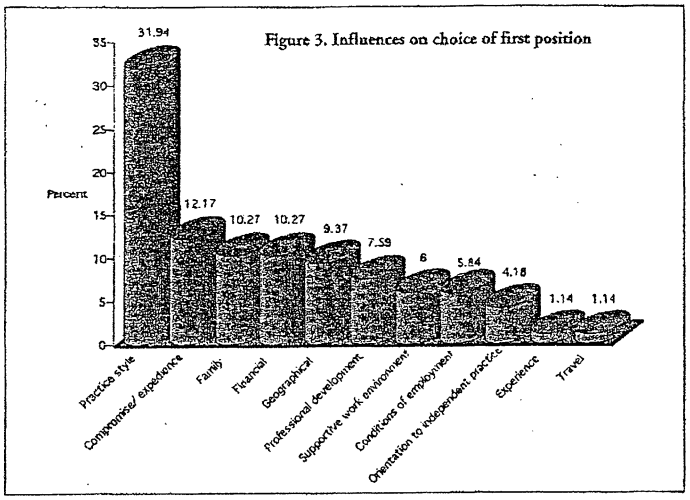
In their current position – changes in reason for taking up the position: Overall 'practice style' remained the most important reason for taking up a position. For those who had taken more than one position, 'family' and 'supportive work environment' became more important influences and 'compromise / expedience' became less so. These reasons mirrored those of respondents who had remained in their first position (see Figure 5).

Continuity of work as a midwife: The majority of respondents had worked continuously since graduation (excluding holidays). 28% of respondents took a break at some stage and the reasons are outlined in Figure 6.

Future practice intentions: 91.2% of respondents intended to continue to work as a midwife. 71.6% intended practising case loading midwifery in the future, citing reasons related to practice style (68.9%). Practice style and wanting to practice independently were the main reasons given for planning to caseload in future practice. Those who were case loading intended to continue and those who weren't were significantly likely to state that they intended to case load in the future (χ^2=5.3, df=1, α=0.05). Those who did not plan to caseload in the future gave professional development opportunities as the most important reason for not doing so.

Movement between caseloading and non-caseloading positions: Movement between caseloading and non caseloading practice was relatively even for each year of graduation, where to-

tal movement remained static for the 1994 respondents ranging up to a net movement of 44% for the 1997 graduates (see Figure 7). In the main, movement was between caseloading and core facility midwifery practice, resulting in experience for these graduates in both the primary and secondary maternity services.



Discussion

An ageing population?

The data collected in this study adds support to the concern (Guilliland 1998) that the midwifery population is ageing. Over 72% of midwives working in New Zealand in 2000 were over 40 years of age (New Zealand Health Information Service, 2000). If the current midwifery programmes are able to produce sufficient graduates to meet current and future workforce requirements, the fact that existing midwives are older is not, of itself, an issue. However, there is currently no national system for establishing and planning workforce requirements that could inform decisions about graduate numbers. Further study needs to be undertaken to establish current and future midwifery workforce requirements within the context of the current maternity services. If the current midwifery educational programmes are not producing sufficient graduates to meet workforce requirements then consideration must be given by educational institutions and government to increasing both the intakes of students and the accessibility of existing programmes for prospective students outside of the main centres.

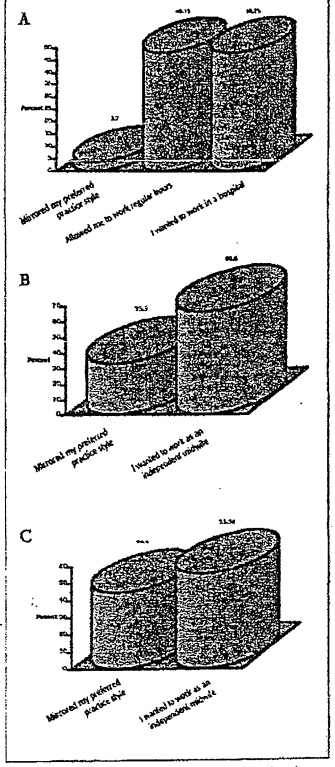
Ethnicity

We had hoped to gather data from a larger group of Maori graduates as anecdotal evidence from midwifery educators indicates that the uptake of direct entry midwifery by Maori is increasing (NZCOM Education Committee, 1994 – 1999). Pakeha (non-Maori) respondents appear to be over-represented in this study. Current New Zealand data relating to ethnicity of midwives is incomplete (Guilliland, 1998) so it is difficult to draw a comparison between the cohort studied and the wider midwife population without further study.

Respondent profile

The profile of New Zealand direct entry midwifery graduates appears to differ somewhat from that of direct entry graduates in the United Kingdom (ENB, 1997). While more than half of both groups have children and are married, there is a significant difference in age. The age difference between the two groups may be explained by the different impetus for the development of direct entry programmes in each country. The United Kingdom (UK) began offering direct entry midwifery programmes as a way of recruiting midwives into the profession and of preparing midwives who were capable of working to the full scope of midwifery practice (ENB, 1997). The UK direct entry programmes have accepted school leavers. In New Zealand the impetus for direct entry midwifery programmes came from consumer demand for autonomous midwives who could offer women an alternative to the medical model of maternity care. Criteria for entry to these programmes have always emphasised life experience and maturity, with a recommended minimum age of 20 years (NZCOM Education committee, 1994 – 1999). Maturity and confidence are necessary for the demands of midwifery in New Zealand. These demands include autonomous practice, self-employment, continuity of care and the intimacy and complexity of the midwife/woman relationship when practised in a partnership model (Pairman, 1999). This preference for older students appears to be supported by the fact

Figure 4
A) Reasons given by those employed in hospital as core midwives for taking up the first position
B) Reasons given by those employed in hospital as case loading midwives for taking up the first position
C) Reasons given by midwives who were self-employed in the first position



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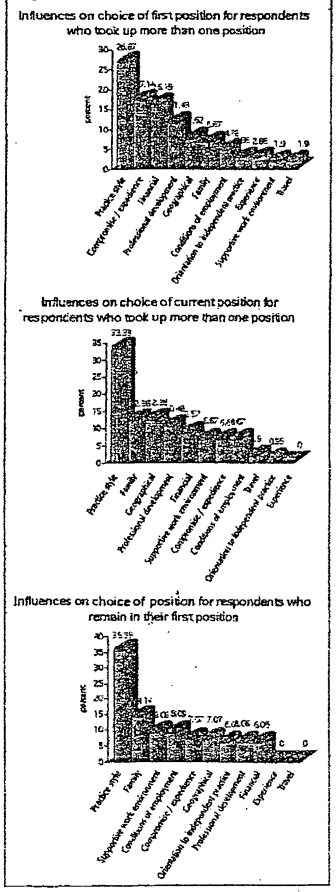
that only 2.8% of all direct entry midwives working in New Zealand in 2000 were under 25 years of age (New Zealand Health Information Service, 2000). Overall, it appears that respondents in this study were drawn to midwifery later in life and after they had had children of their own.

Regions where positions are taken up

Following graduation no respondents took an initial position outside of New Zealand, choosing instead to consolidate their educational preparation by working as midwives in New Zealand first. That respondents from Otago Polytechnic were more likely to take positions in a wider variety of regions may be a reflection of the greater employment opportunities available to Auckland graduates in the Auckland region as compared with employment opportunities in Otago (Guilliland, 1998; National Health Committee, 1999). Another possible explanation for the dispersion of respondents from Otago is that a large number of students in the Otago Polytechnic programme, particularly in the early years, came from outside the Otago region and may have returned home after graduation (Otago Polytechnic Nursing and Midwifery Department Admissions Committee, 1992 – 1998). A third possible explanation is that in their third year of study, Otago Polytechnic students have the opportunity for clinical placements throughout New Zealand. Many use this as an opportunity to network, to 'try out' working in locations of interest, and to establish themselves in regions outside Otago. Until recently, AIT students have tended to have the majority of their placements in Auckland (NZCOM Education Committee, 1994 - 1999).

Figure 5.



Urban/rural/combination

Respondents were asked to indicate for each position whether they worked in a rural setting, urban setting or a combination of the two. These terms were not defined in the questionnaire, so some discrepancy may exist amongst respondents in what they considered to be rural or urban. However, there is a possibility that the programmes had an influence on where graduates went to find work. Unlike AIT, Otago Polytechnic students have a compulsory rural placement in the third year of their programme, thus providing an opportunity for experience of rural midwifery practice and this may be related to a larger number of Otago respondents who worked in rural areas. Guilliland (1998) found that rural and provincial women relied heavily on self-employed midwives for any maternity service and that these women also had fewer choices of maternity carer. Further studies should examine whether formal experience of rural placement in midwifery programmes would increase the number of graduates willing to work in New Zealand's rural areas. It may be necessary to develop strategies to increase access to midwifery education programmes for rural women who wish to practise midwifery in their own areas.

Reasons for taking up employment positions

First employment position

The majority of respondents (57%) were employed in a public hospital in their first position followed by 33.3% in self-employment claiming from Section 51. However, practice type was not confined by employer category as 11.3% of hospital-employed graduates were caseloading in their first position. This reflects the current maternity services where most base hospitals run their own independent midwifery service.

Although caseloading might be the preferred practice style, a guaranteed income, paid holidays, and the opportunity for professional development strongly influenced the respondents' decisions to take up caseloading as employees within a hospital. As expected, reasons related to family and compromise and expedience figured more prominently for all respondents with dependent children than those without.

Current employment position

In the current position practice style remained the most important influence in all positions. However, for those respondents who had more than one position, their reasons for taking up their current position differed by employer. For hospital-employed, caseloading midwives, reasons relating to family and conditions of employment were most frequently stated while self-employed, caseloading midwives most frequently indicated reasons relating to location.

When comparing the two caseloading groups in their current position both still gave practice style as the most important reason for taking up the position. However, hospital-employed caseloading midwives identified professional development, financial and conditions of employment as being more important while self-employed midwives identified reasons related to a supportive work environment. It is noteworthy that those for whom reasons of professional development and conditions of employment were important were primarily employed in a hospital either as caseloading or core facility midwives. This might be because hospital employment may offer a variety of paid leave including study leave that is not available in the same way to self-employed midwives.

First position versus current position – trends in practice style

Over time, from the first position taken following graduation to the current position held by respondents, there was a trend toward caseloading. As most respondents stated that they wished to 'caseload' in their future practice it was clear that they were on their way to achieving this goal. As preparation of graduates for self-employed caseloading practice was a stated aim of both programmes it would appear that Otago Polytechnic and AIT have succeeded in this aim.

Equally important was the number of graduates who worked in public hospitals as core facility midwives. There was consistent movement between caseloading and core facility midwifery practice, resulting in experience for these gradu-

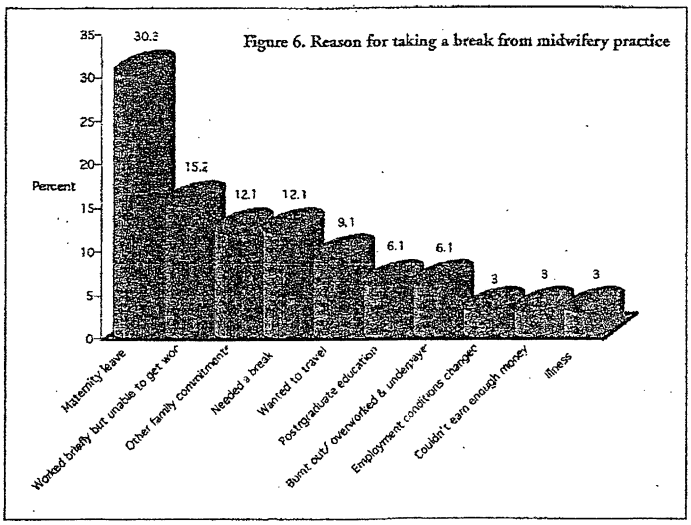


Figure 6. Reason for taking a break from midwifery practice

ates in both the primary and secondary maternity services. Understanding of both aspects of the service can only benefit the maternity service in the long term as the Ministry of Health moves to further integrate the primary and secondary services. As Guilliland (1998) points out there has been concern in the midwifery profession about the lack of experience of midwives remaining in the core after large numbers of midwives moved into self-employed practice from the hospitals over recent years. The midwifery profession is working to redefine the role of the core facility midwife to that of a 'wise woman' in the institutions, who uses her knowledge and expertise in secondary maternity care to support the primary midwife/woman partnership as necessary (Pairman, 1999). The fact that direct entry midwifery graduates have increasingly gained experience in both core facility and caseloading midwifery will help this process of redefinition of midwifery roles. Cooperation between core and caseloading midwives is essential for successful integration of primary and secondary maternity services in New Zealand. For the midwifery profession to continue to exert significant influence over the development of the maternity services in New Zealand, requires midwives who can work autonomously and confidently in all areas of the maternity service.

Future practice

It was heartening to see that most respondents intend to continue to work as a midwife in the future and that so many intend to either continue or to begin to practice caseloading midwifery. Midwives already provide the majority of the maternity services in New Zealand with 73% of women having chosen a midwife as their Lead Maternity Carer in 2000 (Health Funding Authority, 2000).

Respondents from these programmes are experienced in both core facility midwifery and caseloading midwifery and the trend is towards caseloading midwifery.

The challenge for the Ministry of Health is to ensure that there are enough independent midwives to meet the demand and that their work conditions support caseloading practice. That professional development opportunities influenced respondents who chose hospital employment rather than self-employment, suggests that consideration needs to be given to increasing the professional development support available for self-employed midwives.

Conclusion and recommendations for future study

These findings support the preparation midwifery students receive at Otago Polytechnic and AIT. These programmes set out to produce graduates who are able to work independently in any area of the maternity service, and clearly they have achieved this aim. Respondents from these programmes are experienced in both core facility midwifery and caseloading midwifery and the trend is towards caseloading midwifery.

Midwives are the core of the maternity service and increasingly are the only providers for women experiencing normal childbirth. It is essential that enough midwives are educationally prepared for this demand and that midwives can be attracted to work in all areas of New Zealand. While job satisfaction appears to be important in choosing caseloading practice, it may also be important for the profession and government to consider the impact of other factors such as professional development opportunities and financial security if it becomes necessary to provide further incentives for caseloading midwifery practice.

This study raises possibilities for further research. Maori have the fastest growing population and Maori women have higher fertility rates than non-Maori women (Ministry of Women's Affairs, 2000). The number of Maori women entering and completing midwifery programmes needs to be examined as well as wider issues of retention of Maori midwives after registration. This study could also be replicated with graduates from all five midwifery schools to see whether findings are repeated and if there are any differences between educational institutions.

One of the limitations of this study was that we were unable to obtain any meaningful data about midwifery practice in terms of numbers of clients, numbers of women for whom the midwife was the lead maternity carer and hours of work. A further study could examine the practice of midwives and compare various groups of midwives such as rural and non-rural midwives or caseloading and non-caseloading midwives. This kind of information could be useful to the profession and to Government when looking at funding of midwifery services and structuring of maternity services.

This study has been a small descriptive study but it has provided interesting and useful information. It is the only picture we have to date of the midwifery practice of direct entry midwives and it provides a starting point for further research.

The authors wish to acknowledge Otago Polytechnic and the Health Research Council for the funding received for this summer studentship project.

REFERENCES

Australian College of Midwives Inc, Victorian Branch. (1999). Reforming midwifery. A discussion paper on the introduction of Bachelor of Midwifery programs into Victoria. Carlton: Author.

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Where do all the midwives go? *Sally Pairman and Sheridan Massey*

Department of Statistics (1992) Supermap Two: New Zealand census of population and dwellings (Version 4.02) [Computer software]. Wellington, New Zealand: Space-Time Research Pty Ltd.

Donley J. (1990). Autonomy for midwives. New Zealand College of Midwives Journal, November, 7.

English National Board for Nursing, Midwifery and Health Visiting. (1997). An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education. London: Author.

Ernst & Young. (1993a). Framework for programme evaluation. Experimental direct entry midwifery course. Wellington: Author.

Ernst & Young. (1993b). Programme evaluation. Experimental direct entry midwifery programmes. Interim report. Wellington: Author

Guilliland, K. (1998). A demographic profile of self-employed (Independent) midwives in New Zealand. Unpublished Masters thesis. Victoria University of Wellington.

Harris, L. (1995). Evaluation of direct entry midwifery programme. Second interim report. Wellington: Ministry of Health.

Health Funding Authority. (1998). Section 51 advice notice March. Wellington: Author.

Health Funding Authority. (2000). Maternity statistics reference document. Wellington: Author.

Kirk, J, MacKeith, N & Maggs, C. (1994). An evaluation of pre-registration midwifery in England. Bath, England: Department of Health.

MacKeith, N. (1995). The bundles of direct-entry. Modern Midwife, October, 24-26.

Mogevand, T. (1998). Midwifery training in the Netherlands. MIDIRS Midwifery Digest, 8 (3), 280-282.

Ministry of Women's Affairs. (2000). Parent. March. Wellington: Author.

National Health Committee. (1999). Review of maternity services in New Zealand. Wellington: Author.

New Zealand College of Midwives Education Committee. (1994-1999). Minutes of meetings. Unpublished.

New Zealand Health Information Service. (2000). New Zealand workforce statistics - nurses and midwives. [online]. Retrieved June 18, 2001 from World Wide Web: http://www.nchis.govt.nz/stats/nurses.stats.html

Nursing Council of New Zealand. (1996). Standards for registration of midwives. Wellington: Author.

Nursing Council of New Zealand. (2000). Nursing department/school handbook: for tertiary education institutions offering pre-registration midwifery programmes. Wellington: Author.

Otago Polytechnic Nursing and Midwifery Department. Admissions Committee. (1992 - 1998). Minutes of meetings. Unpublished.

Pairman, S. (1999). Partnership revisited: towards midwifery theory. New Zealand College of Midwives Journal, 22, 5-14.

Pairman, S. (2000). New Zealand College of Midwives education framework. New Zealand College of Midwives Journal, (22), 5 - 14.

SPSS Base 9.0 User's Guide (1999) Chicago, United States of America: SPSS Inc.

Tyson, H. (2000). Personal communication.

Accepted for publication: 17/9/01

Pairman, S., & Massey, S. (2001). Where do all the midwives go? A report on the practice choices made by Bachelor of Midwifery graduates. New Zealand College of Midwives Journal, 25, 16-22.

Figure 7. Movement between caseloading and non-caseloading practice by year end of graduation

Caseloading in the first position - by year of graduation

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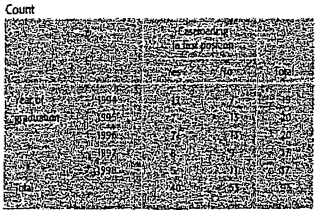

Caseloading in the current position - by year of graduation

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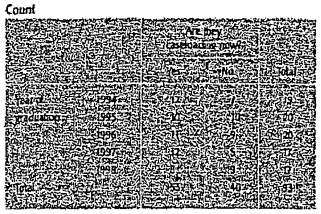

From autonomy and back again: educating midwives across a century

Paper based on keynote address given at NZCOM Biennial conference, Wellington, 16 – 18 September 2004.

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Introduction

The way that midwives in New Zealand have been educated has reflected the role and scope of practice that society expects of midwives. Over the century from 1904 to 2004 midwifery practice has shifted from a position of relative autonomy to dependent practice under medical supervision to full professional autonomy. There are many reasons for this change in scope of practice; in particular the changing place of women in society, changes in societal expectations of childbirth, midwifery's relationship with nursing and medicine, and midwifery's professional development. Across the century midwifery education has evolved in response to the changing status and scope of practice of midwifery. This paper offers snapshots of some of these changes and traces the evolution of midwifery education over the century. In so doing it seeks to highlight the importance of education as a professionalising strategy for midwifery.

Back to the beginning

The formal 'beginning' of New Zealand midwifery education came with the 1904 Midwives Act, the centenary of which was celebrated by midwives throughout New Zealand in 2004. The 1904 Midwives Act itself was a short document of only four pages. It was passed to *"provide for the Better Training of Midwives, and to regulate the Practice of Midwifery"*(Midwives Act, 1904, p.1). The Act established midwifery registration, and provided for the establishment of state maternity hospitals, later named St Helen's hospitals, in which students were to be trained and prepared for registration as midwives.

Until the Midwives Act was passed there were only a few midwives with formal training they had gained overseas before immigrating to New Zealand. Most were lay midwives who learned their midwifery skills from other midwives or local doctors (Donley, 1986; Rattray, 1961). Women managed childbirth amongst the European population, relying on knowledge gained through experience and observation and passed from woman to woman (Coney, 1993). Most women birthed at home or in local unlicensed single-bed maternity or 'lying-in' homes, owned and operated by midwives (Mein-Smith, 1986). Joan Donley, in her book, "Save the Midwife', describes those early midwives or handywomen as part of their community, arriving several days before the birth was expected to look after the household while the pregnant woman rested. The midwife cared for the woman through the labour, delivered the baby, helped the mother to establish breastfeeding and stayed on to help for a few days after the birth so the mother could rest (Donley, 1986). Joan Rattray, in her book titled 'Great Days in New Zealand Nursing' describes Mrs Frampton, a midwife practising in 1897, as

> *A typical pioneer midwife, a woman of robust constitution, who walked many miles to attend patients. Like many of her profession, she had a strong sense of humour.*

When she died at the age of eighty-three she still had an almost perfect set of teeth. (Rattray, 1961, p.27).

Most of these early midwives were undoubtedly very skilled but some probably were not. Certainly there were concerns about midwifery practices and untrained lay midwives were blamed for the high levels of maternal and infant mortality during the 1920s to 1930s (Parkes, 1991).

The 1904 Midwives Act

In 1904, however, the government was concerned at the falling birth rate amongst the 'white' population (Donley, 1986). It was feared that Maori and other non-white races would outnumber the British settlers and gain advantage in the struggle for resources and power in the new colony (Mein-Smith, 1986; Donley, 1986; Coney, 1993). A Royal Commission, established in 1904, blamed the declining birth rate of European settlers in New Zealand and Australia on the 'selfishness' of women who were thought to be deliberately limiting family size (Donley, 1986; Coney, 1993). The reality of women's lives was not recognised in government policy. Women were idealised as mothers but this image applied only to respectable married women, while unmarried mothers received harsh treatment and were expected to go out to work as well as bring up their children. Many women and families suffered from economic hardship (Coney, 1993). Despite the sentiment about 'noble' mothers there was little government assistance other than free maternity care that came as part of the Social Security Act in 1938. Legal access to contraception was difficult until the first family planning clinic opened in 1953 (Coney, 1993). The Domestic Purposes Benefit was not available to single mothers until 1973. For much of the 20th century women's primary role in New Zealand was as a wife and mother. Many of the improvements made to maternity services were to encourage women to do their patriotic duty and have more babies.

Indeed, Grace Neill, Assistant Inspector of Hospitals, utilised these arguments to persuade Premier Richard Seddon of the need to address standards of midwifery practice when she sought to establish the 1904 Midwives Act. According to her son John, Grace Neill had strong socialist beliefs and concern for the plight of women. She was particularly concerned about women birthing in unsuitable surroundings and with little support who could only afford unskilled help for the birth (Neill, 1961). She believed that midwifery training would improve maternity care for women and babies, and that working class women should have access to safer environments for birth (Donley, 1986; Neill, 1961; Parkes, 1991). Grace Neill argued that the way to improve maternity services for women was to require State registration of midwives so that lay-midwives could be phased out and replaced with a new class of competent trained midwife (Neill, 1961; Parkes, 1991).

This midwifery training took place in the seven St Helen's hospitals. These were established between 1905 and 1920 in existing buildings rapidly converted for the purpose. The hospitals provided midwifery services for married women whose husbands earned low wages (Parkes, 1991; Wassner, 1999). However, all women paid a small fee because Grace Neill strongly objected to any implication of 'charity' (Neill, 1961). Grace Neill's successor, Hester MacLean (1932, p. 57) recalled that the hospitals were treated,

More as maternity homes than as actual hospitals, and to have equipment that would not be so elaborate that nurses working outside afterwards would miss it and would be unable to adapt themselves to poor homes with little to work upon.

However, the changes to equipment and techniques that were made from 1925 to reduce the risk of puerperal infection created a more hospital-like environment (MacLean, 1932).

Hospitalisation

Although the midwife-run St Helen's hospitals were the beginning of the state maternity system, most women continued to birth at home until after the First World War. By 1926 58% of births took place in hospitals and this had risen to 76% by 1934 (Mein Smith, 1986). The move to hospitalised birthing took place more rapidly in New Zealand than in other western countries such as America and Britain. According to Phillipa Mein Smith (1986) the move to hospital birthing was largely the result of societal concerns for maternal and child welfare and the growing power and expertise of the medical profession. Healthy children were essential to New Zealand and to the British Empire and therefore maternal welfare became an essential strategy as *"on her health ... depended the health of her child, and the stability of the Empire"* (Mein Smith, 1986, p.4). High maternal mortality rates in the 1920s were linked to puerperal sepsis, septic abortion and toxaemia and the resulting campaign for 'safe maternity' led to rapid medicalisation of childbirth (Mein Smith, 1986).

The campaign for 'safe maternity' was launched in 1924 under the slogan *'Perfect motherhood is perfect patriotism'* (Mein-Smith, 1986, p.23). The campaign emphasised antenatal care, asepsis, hospital policy and training of midwifery and medical students. The main thrust of the campaign was on efforts to eliminate puerperal sepsis, as a major cause of maternal death.

Health Department doctors believed that the cause of puerperal sepsis was exogenous, and that staff could pass on a hospital or home acquired infection from woman to woman. Obvious methods of transmission were during vaginal examinations or instrumental deliveries or when women in hospitals used the same baths (Mein Smith, 1986). Standardised aseptic techniques for labour and care during the puerperium were introduced through the H. Mt. 20 Regulations. These regulations involved protocols to reduce infection through aseptic techniques such as pubic shaving, enemas, swabbing of the perineum with antiseptics and the use of sterile drapes, surgical scrubbing and the wearing of gowns and masks by all birth attendants (Wassner, 1999). Labour was fragmented and the woman was moved from the admission room to the first stage room and to theatre for delivery. All equipment was sterilised, including packs of sheets and birthing equipment for midwives to use at homebirths (Mein Smith, 1986). In the postnatal period women were kept in bed for up to ten days post-partum and were subjected to four hourly perineal swabbing with antiseptics for the first few days. Babies were kept separately in nurseries, only being brought to their mothers for the strict four-hourly feeding regime (Wassner, 1999). These regulations dominated midwifery practice for the next thirty or so years, with aspects continuing in some parts of New Zealand through to the early 1980s. While aiming to prevent the spread of infection these regulations also had the effect of routinising childbirth and providing a context for birth that must have disturbed normal physiology and almost certainly affected midwifery's ability to promote normal birth.

Largely as a result of the H. Mt.20 Regulations, the maternal mortality rate significantly reduced by 1935. Mein-Smith (1986) notes the irony that it was the high standards of midwifery care that assisted in the transition to hospitalised childbirth. She states,

> *Before the end of the 1920s some hospitals exposed women to greater risks from sepsis than did domiciliary midwifery, but a number, particularly the Department's own St Helen's hospitals set the standards of asepsis which were instrumental in producing a steady decline in puerperal fever after 1927. Hospitalisation became perhaps the only way to effect a rapid change in the high maternal mortality rate* (Mein-Smith, 1986, p.64).

The seduction of pain relief

The trend to hospitalisation was unstoppable after 1935 as doctors promoted hospital birth with a doctor present as the safest and easiest maternity care. Doctors used the promise of 'pain free childbirth' to lure women to hospitals under their care. Anaesthesia and analgesia in the form of 'twilight sleep' was only available from doctors, mainly in private medically run maternity homes although some may have used it in homebirths. A mixture of morphine and scopolamine, 'twilight sleep' produced analgesia and sedation as well as amnesia. It was later found not to relieve pain in all cases, but as women could not remember the pain it was promoted as the solution to 'pain free birth'. The Health Department strongly opposed the use of twilight sleep. In high doses it caused almost total anaesthesia and could cause death or respiratory problems for the baby. The Department called it the 'Half-Dead Baby System' and linked it to an increase in the use of forcep deliveries when labour slowed as a result of the sedation (Mein Smith, 1986. p.83; Coney, 1993). The Health Department did not oppose all forms of analgesia and from 1926 midwives were authorised to administer chloroform in small doses during labour. However, the fact that only doctors could offer twilight sleep and other forms of analgesia gave them an advantage over midwives and more women began to seek care from doctors.

Doris Gordon, one of the pioneers of 'twilight sleep', and founder of the Obstetrical Society, encouraged women's groups to lobby government for access to twilight sleep in the St Helen's hospitals (Donley, 1986). Women's groups within the Labour Party took up the right to pain relief as an equity issue. They argued that wealthy women in private care could afford modern anaesthetics and this should be equally available to women in public maternity hospitals including St Helen's. As only doctors could provide this pain relief, they should be present at every birth.

The conflict over pain relief between the Health Department and the Obstetrical Society characterised the clash in ideology evident in the years between 1920 and 1939. The view of doctors within the department was that,

> *Midwifery is branch of preventive medicine because pregnancy, labour and the puerperium are physiological and not pathological states, and the woman at these times is not a sick woman. The whole end and object of midwifery is to maintain the physiological character of these states so as to prevent illness and injury to the woman and secure the birth of a healthy and uninjured child* (Tracy-Inglis cited in Mein Smith, 1986, p.82).

On this basis the Health Department promoted a midwifery-led maternity system as the most appropriate for New Zealand. Midwives would care for most women and doctors

would only be involved when complications arose. The Obstetrical Society on the other hand declared that,

> *Labour by the process of civilisation had become 'abnormal and pathological' and was now a 'surgical operation' .... Prominent obstetricians overseas are emphatically teaching that pregnancy from start to finish is a process fraught with danger..."* (Mein Smith, 1986, p.82).

The Obstetrical Society led an organised campaign by doctors to argue for a maternity system in which all women would be attended at birth by a doctor, assisted by a midwife or maternity nurse (Mein Smith, 1986). It was the focus on pain relief in normal labour that eventually saw doctors winning their campaign for the control of childbirth and led to the dominance of the medical model approach to birth on the provision of maternity services in New Zealand that continues today. The introduction of pain relief in normal birth established a role for doctors within public maternity hospitals. This was cemented with the 1938 Social Security Act that provided for free medical care for all women in childbirth. As a consequence of these changes the role of the midwife reduced to one of assistant to the doctor.

The role of the midwife

Within this context the role of the midwife changed rapidly. Under the 1904 legislation midwives had some autonomy in relation to normal childbirth. Without actually stating what midwives were able to do the Act made it clear that the midwifery scope of practice had limitations. Midwives were not authorised to *"grant any medical certificate or any certificate of death or still-birth, or to undertake the charge of cases of abnormality or disease in connection with parturition"* (Midwives Act, 1904, p.3). By the 1925 Nurses and Midwives Act this clause had disappeared, perhaps because by then medical involvement in all births, including those with complications, had become the norm (Mein-Smith, 1986). Instead the scope of practice of a midwife now read, *"to attend a woman in childbirth in any case where a registered medical practitioner has not undertaken responsibility for the care of the patient"* (Nurses and Midwives Registration Act, 1925, p.21).

Although midwives could practice autonomously in 'normal' childbirth, both Acts still gave significant powers of supervision and surveillance to doctors (Papps & Olssen, 1997). The 1904 Midwives Act established the Registrar (a doctor) with responsibility for registration of midwives and in 1925 this role was taken over by the Nurses and Midwives Board (consisting of two doctors, two nurses and only one midwife). District Health Officers (also doctors) were given powers to supervise midwives, to suspend midwives to prevent the spread of infection and to investigate charges of professional misconduct against midwives (Midwives Act, 1904; Nurses and Midwives registration Act, 1925; Papps & Olssen, 1997). The 1925 Nurses and Midwives Registration Act largely placed control of midwifery into the hands of nursing and from that point onwards midwifery became increasingly subsumed into nursing until in 1971 the Nurses Act removed the word 'Midwife' from the title altogether and required midwives to practise only under the supervision of doctors.

Midwifery education

The 1904 Midwives Act provided three routes to midwifery registration. Women of good character with no formal training, but who had been practising midwifery for at least three

years prior to the introduction of the Act, could apply for registration within the year following enactment of the legislation (Hill, 1982; Papps & Olssen, 1997; Midwives Act, 1904). Likewise, midwives with formal training from recognised training schools overseas could be registered (ibid). Lastly, women could gain registration after successfully completing training through the state maternity hospital programmes (ibid). There was a six-month course in midwifery for nurses registered under the Nurses Registration Act 1901 and a twelve-month course direct entry course (ibid).

Interestingly, in the 1904 Act midwifery students were referred to as *'pupil nurses'* whether they were actually nurses or not (Midwives Act, 1904, p.2). On payment of the prescribed fee pupil nurses could, through a State Maternity Hospital (later named St Helen's Hospitals), *"be carefully instructed in all duties required for the welfare of mother and infant during and immediately after childbirth"* (ibid). This 'instruction' was to be given to pupil nurses by *"means of lectures and practical teaching in and outside of the hospitals and by a period of midwifery work"* (ibid). In order to be registered, pupil nurses were required to attend lectures at a State Maternity Hospital for the required period of time, attend the prescribed number of cases of labour and through an examination in the prescribed subjects satisfy the examiners as to their proficiency.

These requirements continued under the 1925 Nurses and Midwives Registration Act although the Nurses and Midwives Registration Board prescribed a syllabus for midwifery training in 1927. The syllabus closely followed the H. Mt. 20 Regulations and included such topics as the duties of a midwife, the principles of asepsis and antisepsis, the management and aseptic techniques of labour and the puerperium, methods of preventing the spread of infection, antenatal diagnosis and treatment, the management of normal pregnancy, vaginal examination, the prognosis of labour, the conduction of labour, the management of the puerperium, the elements of house sanitation, the cooking and preparation of food. There were set numbers of clinical experiences such as 30-40 vaginal examinations, 20 rectal examinations, 20 conductions of labour, 60 antenatal patients examined, and 10 puerperal patients nursed (Hill, 1982).

The Nurses and Midwives Registration Board also instituted linkages between midwifery and nursing education. By 1925 both nurses and direct entry students were required to complete a course in maternity nursing before entering midwifery training. Registered nurses completed an eight-month course while untrained (direct entry) women completed twelve months. It then took a further four months for both groups to obtain midwifery registration. This was later extended to six months and by 1930 nurses had to complete six months maternity nurse training and then six months midwifery, while untrained (direct entry) women completed an eighteen-month maternity course and six months midwifery (Hill, 1982).

Despite the linkage in training there were recognised differences between midwives and nurses in relation to their scope of practice. Midwives could take sole responsibility for maternity cases (especially those in rural and remote areas) and only involve a doctor for complications; midwives could run private maternity homes; and midwives alone were eligible to take up positions as staff nurses or matrons in maternity hospitals and would thus be responsible for training pupil midwives (Donley, 1986; Hill, 1982). Maternity nurses

worked with doctors in the provision of the majority of maternity care thereby reducing the need for all nurses to hold midwifery registration.

In 1956 maternity training was integrated into the three-year general nursing curriculum, leading to a double certificate as a registered nurse and registered maternity nurse (Donley, 1986; Wassner, 1999). This new general and maternity nurse training heralded the end of the separate 18-month maternity nurse training which was gradually phased out over the next 20 years bringing the direct entry route to midwifery to an end (Donley, 1986; Wassner, 1999). Fortunately midwifery training and registration remained but the training was available in only three St Helen's hospitals (Auckland, Wellington and Christchurch) while the other public and private hospitals with maternity facilities provided the training of nurses and the remaining maternity nurse programmes. Midwifery graduate numbers were insufficient for the maternity service and midwife shortages remained, particularly in rural areas (Hill, 1982).

The result of these changes in midwifery education was the slow integration of midwifery with nursing. It became common practice for registered nurses, who had no intention of practising midwifery, to obtain midwifery registration in order to gain promotion to positions of authority such as that of matron (Hill, 1982). Indeed, according to her son, even Grace Neill had envisaged that *"no nurse would be eligible for the higher ranks of the profession unless she held the certificate of registration in both nursing and midwifery. The (St Helen's) hospitals would therefore be staffed mainly by women who had already completed their nursing training"* (Neill, 1961, p.51).

Despite starting with separate legislation it appears that most midwives did not see themselves as members of a profession that was separate to nursing. Indeed it seems likely that it was only the imminent demise of midwifery following the 1971 Nurses Act and the active opposition of the Nurses Association to midwifery's attempts to protect its definition, its scope of practice and its education that provided the impetus for midwives to take a stand together to try and claim their separate identity from nursing. I will return to this later.

St Helen's hospital midwifery training

As an environment for midwifery training, the St Helen's hospitals must have been reasonably 'midwife-friendly', not because the midwives didn't have to work extremely hard, but because there was a considerable degree of midwifery autonomy and control over practice, albeit that this was exercised by midwives in a hierarchical system. The medical profession had opposed both the 1904 Midwives Act and the establishment of the St Helen's hospitals, because they saw midwives as competitors for patients, and also because they feared state control over their practice (Donley, 1986). Despite this opposition the St Helen's hospitals flourished, and for twenty years provided midwifery training, midwifery-led care in the hospital and the community, and a female dominated maternity service, as it was Health Department preference to appoint female doctors to work in the St Helen's hospitals (Donley, 1986; MacLean, 1932). Midwives staffed the hospitals, providing most of the care although the medical officers were called in for emergencies. Hester MacLean described the position of medical officer in St Helen's hospitals as part-time and non-resident, saying,

> *The matron and her staff carry on all normal confinements, and only send for the medical officer if necessary. They (medical officers) also deliver lectures to the nurses preparing them for the State examinations, apart from that, they have no share in the management of the hospitals, but are, of course consulted frequently and visit regularly* (MacLean, 1932, p.60).

The St Helen's hospitals trained only midwives, while maternity nurses were trained in other private and Hospital-Board controlled maternity facilities. Midwifery students lived on the premises, received no pay for their work and keep, and in the beginning had to pay a fee of ten pounds (or twenty pound for the twelve-month course) towards their training (Neill, 1932; Lambie, 1956; Hill, 1982). Mary Lambie, Director of Division of Nursing from 1927 to 1949, recalled her midwifery training at St Helen's hospital in Wellington in 1926 in her memoirs (Lambie, 1956). She noted that students had to provide their own uniforms, one for indoors and one for outside work, as well as their own bag and equipment. They worked ten-hour days and night duty on top of this, and Mary had only one day off in her ten-month training (ibid). The medical officer and registered midwives provided the teaching, most without any formal teaching skills. Students attended women in the hospital and at home. If a woman was having a normal birth then a midwife and trainee took responsibility. Many homebirths took place in poor conditions, lacking means to boil water or make a clean bed. Linen was provided from the hospital and taken away afterwards for washing (ibid). Mary Lambie found the domiciliary experience to be *"excellent and the patients were certainly given individual consideration"* (ibid, p. 55).

This early midwifery training was focused on tasks and routines and the acquisition of knowledge through lectures and through experience. Marion Shepherd trained at the Christchurch St Helen's from 1922 –1923 and she wrote of her experiences,

> *A trainee began literally on her knees. There was daily washing of all the linoleum or bare board floors in the corridors, labour ward and general wards. Three or four times daily a large pile of nappies were washed by hand and put through the wringer, boiled, and hung out to dry, if fine. The hopper had to be stoked with coal to heat the coppers in which the nappies were boiled. If the handyman was not on duty the trainee nurses saw to the fuelling* (Shepherd, 1989, p.94).

Marion Shepherd told of 12 hour days that began at 5.30 am and an expectation that trainees would be called during the night even when they were off duty. There was only one telephone and the trainees took turns sleeping in the 'telephone room' in case there were night births. Trainees worked in the hospital and in the community visiting women in their homes by bicycle. She talked of sheer exhaustion, broken sleep, early mornings, shift work, long hours and hard physical work. Study had to be fitted in around these duty hours. Of the district rounds she said this,

> *Rising was even earlier as we had to leave by 5.30 am in order to begin our first case by six as we sometimes fitted in eight for the day. "After treatment" meant sponging the mother, making her bed, bathing the baby and rinsing all soiled linen. Two or three visits were completed before breakfast at the hospital around 8.30. We replenished our supply bags and set off again on our bikes and hopefully finished by 2pm. A hot dinner would be kept for us at the hospital. After tea we cleaned and*

sterilised our bags, wrote charts and reports and made gruel for the patient's 7pm supper (Shepherd, 1989, p.96).

Competition with medical training
While the St Helen's Hospitals were established as a training ground for midwives, conflict with the training needs of medical students soon came to a head (MacLean, 1932; Neill, 1961). Dunedin provided the first centre for medical training in New Zealand and when the Dunedin St Helen's opened in 1905 the Otago Medical School demanded access for medical students. Grace Neill and Richard Seddon opposed this access, arguing that the St Helen's hospitals were not charitable institutions, but institutions provided by the State to which women paid fees to attend. Therefore women using these services had the same rights as women who paid for private maternity care from a doctor and midwife. This included the right not to be cared for by medical students (MacLean, 1932; Neill, 1961; Donley, 1986).

A solution was found when Dunedin Hospital authorities and the Medical School were permitted to buy the Refuge in Forth Street and convert it into the Forth Street Maternity Hospital (later renamed 'Batchelor Maternity Hospital) (Wassner, 1999). The refuge for unmarried mothers had closed in 1904 and was converted into a maternity hospital for the teaching of medical students and nurses by 1907. Labourer's wives and unmarried women were to be admitted (ibid). Women were expected to agree to allow attendance by students as, *"Objections to this are purely sentimental"* (Otago Daily Times report 20/5/07, cited in Wassner, 1999, p.25). Eventually medical students also gained access to other hospitals throughout New Zealand including the Salvation Army hospitals such as 'Redroofs', in Dunedin. In 1929 medical students gained access to the St Helen's hospitals, but competition between midwifery and medicine in the areas of education and practice has remained through the century.

Competition with nursing
So too has competition between nursing and midwifery. As far as doctors were concerned maternity nurses provided the ideal assistant for childbirth and their preference for maternity nurses over midwives was one factor in Nursing's promotion of maternity nurse training. In 1937 midwives, with the support of the Health Department, managed to retain midwifery training programmes against strong medical and nursing arguments for a single maternity-nursing workforce to support doctors (Lambie, 1956). By 1957 when maternity nursing was incorporated into general nurse training and the direct-entry route to midwifery came to an end, doctors objected even to the maternity nurse training because it impacted on the 'clinical experience' available for medical students (Donley, 1986). The number of midwives training was reduced to make way for sufficient numbers of maternity nurses, but even so there were shortages in both groups. By the passing of the 1971 Nurses Act midwifery was virtually indistinguishable from nursing and there was little to set it apart as a separate profession.

Women fight back
As described the management of childbirth in hospital under the H.Mt. 20 regulations was a rigid and highly medicalised surgical procedure (Parkes, 1991). Women were not happy with this care and in 1937 the National Council of Women complained to the Committee of

Inquiry into Maternity Services about the treatment of women. They cited frequent rectal examinations performed without consent or explanation, the sterile hospital environment, the lack of support for women, the lack of privacy, the separation of women from their babies and the streamlined procedure of four hourly pans and swabs for the ten days after birth (Parkes, 1991). None the less this approach to childbirth became the norm, particularly after the Nurses and Midwives Board incorporated it into the midwifery curriculum in 1927. It was not until the 1960s that protests from women resulted in some softening of this approach.

During the 1960s both the midwifery and general and maternity nurse curricula underwent modifications to reflect new knowledge within obstetrics, psychology, physiology and pathology and society's changing views on childbirth. There was a greater emphasis on antenatal care and antenatal education, which included physiotherapy classes in preparation for labour (Hill, 1982; Wassner, 1999). Women, through newly established consumer groups such as the Federation of New Zealand Parent Centres, had begun to question the attitudes and regimented procedures they encountered. They demanded more involvement in their own care and a more family-friendly and humanised approach to childbirth services (ibid). Heidi Wassner summarised the key areas of change between 1960 and 1972 as,

> *A softening of the harshly clinical environment in the labour wards, less bed rest, early mobility, showering, rooming-in, demand feeding, participation of husbands during pregnancy and labour, and child visiting* (Wassner, 1999, p.93).

By this time New Zealand was leading the world with its low maternal death rate and the advent of antibiotics further reduced the fear of cross-infection and the need for rigid aseptic procedures (Hill, 1982; Wassner, 1999). However, despite the more relaxed and 'home-like' approach of the maternity hospitals, advances in obstetric knowledge led to greater intervention in birth in other ways. For example, new forms of analgesia such as Diamorphine and Pethidine were administered in four-hourly routines; caudal blocks and epidural injections were used for forcep and caesarian section deliveries; the availability of the synthetic oxytocic, Syntocinon, meant that labour could be augmented and shortened (Wassner, 1982). The context was one of contradiction and conflicting perspectives.

On the one hand maternity-nursing training (and possibly midwifery training) focused on birth as a normal life event. On the other hand it was still treated as a regimented procedure where each woman experienced the same strict routine care that took no account of her individual needs or wishes. Heidi Wassner's account of the midwifery and medical care given to women through the 1960s and 1970s provides some insight into these conflicting attitudes. For example, she said of episiotomies,

> *(They) were performed more and more often. From a midwife's point of view, they were not always essential, and they were often detrimental to a woman's comfort and recovery* (Wassner, 1999, p.95).

As the context for pregnancy and birth became more medicalised there was increased reliance on technology to the detriment of clinical assessment skills.

> *The trends which emerged during the 1960s to 1970s were: more teamwork, more frequent observations of pregnant women, women in labour and babies, and more interventions. During labour the fetal hear rate and maternal pulse were recorded half-hourly, and maternal blood pressure and urine were checked two-hourly. The*

> *mother's temperature was recorded four-hourly. Many women were monitored with a 'cardiotocograph', which measures uterine contractions, and makes the fetal heart beat audible. The eyes replaced the hands, to the extent that some midwives wondered how medical students conditioned to such high technology, would manage outside an obstetrical environment like the one at Queen Mary Hospital.* (ibid, p.101).

By the early 1980s maternity consumers were expressing concern about the increasing technology and intervention characterising the maternity services, and the lack of control for women and their families over their birth experiences. Consumer groups such as Parents Centre New Zealand and the Home Birth Association identified the threat to midwifery of inadequate education and lack of professional autonomy. Without well-educated and autonomous midwives, women feared they would have no chance of reclaiming birth as a natural process over which they had some control and could make their own decisions. Maternity consumer groups actively campaigned for changes to midwifery education that would produce a midwife capable of working within the full scope of midwifery practice and supporting women to have the birth experiences they sought (Strid, 1987; Dobbie, 1990; Kedgley, 1996).

Midwifery education as the focus of disagreement with Nursing

By the time these women's groups were advocating for an autonomous midwife, midwifery itself was at its lowest point. By 1971 the word 'midwife' had been removed from the title of the legislation altogether. Although the separate register for midwives was retained, midwifery was seen as a specialist postgraduate area of nursing practice rather than a separate profession in its own right. Midwives had lost their relative autonomy and worked instead with delegated authority under the supervision of doctors. The maternity service no longer needed autonomous midwives because the majority of women gave birth in hospitals under medical care. Childbirth was seen as a pathological event requiring hospitalisation and medical intervention in order to achieve a safe outcome. In 1979 the six-month midwifery courses were closed and instead midwifery became an 'option' module within the polytechnic-based Advanced Diploma of Nursing.

Interestingly it was this downgrading of midwifery education that provided the catalyst for midwives to become politically active in an effort to claim a separate identity to nursing. For many midwives midwifery education highlighted their differences with nursing and through the 1970s and 80s the Midwives Special Interest Section of the New Zealand Nurses Association (NZNA) was largely at odds with their parent body over the issue of midwifery education. Eventually midwives realised that NZNA was always going to put the needs of the larger group of nurses ahead of those of the smaller group of midwives and the decision to form the New Zealand College of Midwives was taken. The impetus for this was largely the result of two main areas of disagreement; how should a midwife be educationally prepared and was a midwife also a nurse?

Advanced Diploma of Midwifery

Midwifery education was swept along with changes made to nursing education in the 1970s. Canadian nurse-educator, Dr Helen Carpenter, was invited to New Zealand to advise on nursing education. Her report provided a catalyst for major change in the way that

nursing education was understood and delivered. It culminated in a shift from hospital based apprentice-style training to a polytechnic-based student focused education system (Papps, 1997). It also shifted the prescriptive curricula to more liberal and theoretical nursing education that prepared the 'comprehensive nurse' who would be able to provide care in a variety of health care settings. Carpenter saw midwifery as post-basic nursing and argued that this course should be improved by shifting it into the tertiary system (Donley, 1986).

The Midwives Section immediately sprang into action presenting remits at NZNA conferences in 1971 and 1973 calling for the St Helen's hospital midwifery programme to be strengthened by extending it from six to twelve months. The Section forwarded a draft curriculum for a one-year programme to the Nursing Council and received support for their arguments from a Department of Health report on Maternity Services (Hill 1982). However, these moves for a one-year hospital-based midwifery programme were unsuccessful. In 1979 the St Helen's midwifery programmes were closed and midwifery training was only available through the Advanced Diploma of Nursing (ADN) programmes offered in four polytechnics in Auckland, Hamilton, Wellington and Christchurch. Nurses with two years post-registration experience could undertake a one (academic) year full-time programme at a Polytechnic to advance their nursing knowledge and practice. Within the ADN programmes there were various options such as maternal and child health, community health nursing, medical / surgical nursing and psychiatric nursing (NZNA, 1984). Midwifery was incorporated into the maternal and child health option as a sub-option. Unlike the other options nurses in this option were required to meet not only academic requirements of the maternal and infant health option, but also the midwifery registration requirements of the Nursing Council of New Zealand, including passing the State Final examination.

The Midwives Section was active in its opposition to the ADN/Midwifery option. The main issues identified were the workload required to complete two programmes concurrently, the limitations of the theory and practice components (only 10-12 weeks of clinical experience), the loss of an apprenticeship model, and the resulting inadequate level of preparation for midwifery practice of the graduates (Kennedy & Taylor, 1987; NZNA, 1987). An unfortunate consequence of the transfer of midwifery education into the ADN programme was that many nurses decided not to pursue midwifery or they left New Zealand to undertake midwifery education overseas. From 1981 – 1987 the numbers of midwives training and registering in New Zealand dropped from an average of 157 per year to an average of 23 per year (Donley, 1986). The effect of this dramatic decrease in midwives is still being felt in New Zealand's midwifery shortages today.

The Midwives Section succeeded in changing NZNA policy from support of the ADN Midwifery option to support of the proposed separate midwifery programme by submitting remits to the NZNA annual conferences in 1980, 1982 and 1985, which were passed. Despite changes in policy direction signalled at these conferences, NZNA did nothing to give effect to the changes. Indeed, in its 1984 policy on nursing education, NZNA considered that the resolutions seeking the separation of midwifery training from the ADN programmes caused *"a problem as yet unresolved by NZNA"* that posed *"professional and educational difficulties"* (NZNA, 1984, p.33). NZNA argued that midwifery knowledge

and skills were post-basic nursing because they built on nursing knowledge and skills. Educationally the Advanced Diploma of Nursing was designed to extend basic nursing skills and therefore, because midwifery involved advanced skills, it should be taught within the ADN (NZNA, 1984).

Interestingly this policy statement on nursing education was at odds with another statement released by the NZNA Midwives Section in April 1984 titled, 'Report of the Working Party looking into Education for the Role, Scope and Sphere of Practice of the Midwife in New Zealand' (National Midwives Section, 1984). This policy retained nursing as a prerequisite to midwifery but supported separation of midwifery education from the ADN. Thus by 1984 NZNA had two separate policies on midwifery education and each was at odds with the other. It was not until 1989 that NZNA produced a Midwifery Policy Statement that properly reflected the views of its midwifery members, but by then it was too late to stop midwives leaving NZNA to form their own professional organisation (NZNA, 1989).

Is a midwife also a nurse?

The second, and related, area of contention between midwives and NZNA was the generally held view that midwives must be nurses first and that midwifery education *"builds on the nursing concepts learned in the basic nursing programme"* (NZNA, 1981, p.9). NZNA policy clearly stated that midwives were nurses but from the early 1980s the Midwives Section lobbied to adopt the World Health Organisation (WHO) Definition of a Midwife, which stated that a midwife was a 'person' rather than a nurse. The Section was successful in getting the WHO definition accepted as policy in 1985. However, disagreements remained about the preparation and role of the midwife and not just between nurses and midwives, but also between midwives themselves. A focus for this tension was the small number of domiciliary midwives in practice. Although the 1971 Nurses Act had removed midwifery autonomy and required a doctor to be present at every birth, the domiciliary midwives were almost an exception. These midwives came closest to the WHO definition of a midwife because they provided continuity of care in the community from pregnancy through to the postpartum period. They were out of step with the majority of doctors, nurses and midwives who objected to domiciliary midwifery and homebirth. Doctors, nurses and midwifery groups attempted to control the practice of domiciliary midwives and reduce the number of homebirths through the implementation of various policies.

NZNA proposed a set of minimum standards for all domiciliary midwives, including two years continuous prior employment in a maternity hospital and an assessment of the midwife's suitability and competence to be carried out by the Principle Nurse and an Obstetrician (NZNA, 1981). Obstetricians influenced Board of Health policy that suggested ways to make maternity hospitals more appealing so that women would not choose home birth and that established so many 'risk factors' requiring referral to an obstetrician that hardly any woman fitted the category of 'normal' let alone met the criteria required to have a homebirth (Board of Health Maternity Services Committee, 1979, 1982). Some influential members of the Midwives Section also worked against their domiciliary midwifery colleagues by supporting these nursing and medical strategies and by writing their own policy in opposition to home birth (Midwives Section in NZNA, 1981).

These actions caused a major rift amongst midwives and led to domiciliary midwives leaving NZNA and establishing the Domiciliary Midwives Society (DMS) to represent their views. Fortunately for midwifery the DMS was able to successfully oppose moves to transfer domiciliary midwives' contracts for service from the Health Department to hospital boards and under medical control. This meant that when the Nurses Amendment Act was passed in 1990 there was an existing mechanism to enable midwives to claim payment directly from the Maternity Benefit Schedule managed by the Department of Health. This provided the opportunity for midwives to work independently rather than be employed by hospitals, a factor that has been crucial to the development of midwifery professional practice since 1990.

Separate midwifery programmes

The continual lobbying of the Midwives Section for separate one-year midwifery programmes for registered nurses from 1971 onwards finally bore fruit in 1987. Karen Guilliland and I represented the Midwives Section at the NZNA conference in 1987 where it was announced that there was soon to be a meeting to discuss midwifery education. Against strong opposition from the NZNA Executive Director, who had not planned to take any midwives to the meeting, we insisted on the Midwives Section being represented at the meeting. At the Annual General Meeting of the Midwives Section soon afterwards, Karen and I were nominated to represent the Section at this meeting (National Midwives Section 1987).

At the meeting we were the only midwives amongst a number of nurses including the NZNA Director, Gaye Williams and the Chief Nurse, Sally Shaw. Sally Shaw presented four options for midwifery education: direct entry, separate one-year course, status quo (ADN) or a dual option of ADN and separate. Not surprisingly we were the only two in favour of direct entry and the nurses did not consider it a serious option. One person told us it would happen 'over her dead body'. The nurses were in favour of the status quo or dual option. Gay Williams supported the status quo option rather than the (by then) NZNA policy of separate courses. The Chief Nurse listened to the discussion but had the power to make the recommendations to the Minister of Health.

Eventually on 7 December 1987 the Ministers of Health and Education and the Acting Minister of Women's Affairs issued a joint press release announcing that a *"dual training option"* would be introduced in 1989 (Ministers of Health, Education and Women's Affairs, 1987). Midwifery education would be available separately to the Advanced Diploma in Nursing, although the ADN Midwifery Option would continue to be available in a limited number of places. It would also remain available for midwives seeking further qualifications. Midwives met this compromise with some excitement. Following the recommendations of the Working Party on Midwifery, Bridging and Related Courses separate courses were commenced in 1989 at Auckland Institute of Technology (AIT), Wellington Polytechnic and jointly between Otago and Southland Polytechnics (Pairman, 2002). The ADN Midwifery option continued at Waikato and Christchurch Polytechnics.

In the first example of the collaborative approach that has characterised midwifery education over recent years, representatives of the educational institutions were brought together for a week in Auckland in 1988 to develop guidelines for these new separate

midwifery programmes. The intention of the Health and Education Departments was to evaluate the separate programmes against the ADN programmes over three years and then decide which type of programme would continue.

However, the evaluation was overtaken by other events. Nurses refused to enrol in the ADN/Midwifery programme, insisting instead on access to the one-year midwifery programme. This demand from students led to both Waikato and Christchurch Polytechnics closing their ADN/Midwifery programmes in 1991 and commencing one-year separate programmes in 1992. The polytechnics were able to commence the separate programmes without approval from the Health and Education departments because of the Education Act passed in 1990. Amongst other things this Act removed government control over funded places for health education programmes and opened up a more free-market approach. The Ministries of Education and Health were restructured, the evaluation was never completed and the ADN/Midwifery option ceased without any policy decision to do so being made. The separate midwifery programmes themselves only lasted another few years, as eventually registered nurses were able to enter the direct entry Bachelor of Midwifery programmes. With some credit for prior learning nurses could complete the degree programme in two years instead of three.

Despite their brief time span the separate midwifery programmes were important milestones in midwifery education development. The provision of one year of specific midwifery education instead of the briefer 'option' within a post-basic nursing programme was the first step to raising the profile of midwifery and recognising the potential of midwifery as a major provider within maternity services. It also set the direction for further separation from nursing that would follow the 1990 Nurses Amendment Act. Although the separate programmes began before the legislation changed they used the WHO Definition of a Midwife to set the boundaries of what a midwife needed to learn in order to practise. The curricula used words such as 'autonomy' and 'continuity of care' and follow-through clinical experiences were sought for midwifery students. Indeed when the Otago/Southland programme drafted a brochure to inform pregnant women about the needs of midwifery students to access 'follow through' clinical experiences, the Southland Branch of the New Zealand Medical Association (NZMA) tried to take legal action to stop its development (Macalister Mazengarb, personal communication 10 March 1989). They objected strongly to the WHO definition of a midwife that was listed on the pamphlet and were worried that midwives might try to work as autonomous practitioners in Southland. The notion of informed decision-making was another they had difficulty with.

Separating from Nursing

From 1986 midwives discussed the need to separate from Nursing's professional body (now called the New Zealand Nurses Organisation) and during 1988 the 10 regional Midwives Sections of NZNO all closed down and reopened as regions of the New Zealand College of Midwives (NZCOM) (Pairman, 2002). NZCOM was formally opened on 2 April 1989. They were heady days and midwives were buoyed with support from women and the shared political activity of the time that in 1990 would result in legislative change and the reinstatement of midwifery autonomy. NZCOM presented an exciting vision of the future of maternity services for women and the role that midwives could play in this.

Direct entry midwifery

In midwifery education the focus had moved to direct entry. The Direct Entry Midwifery Taskforce was established in 1987 as a sub-group of Save the Midwives, a consumer group that was itself established in 1983 to fight the proposed 1983 Amendments to the Nurses Act 1977 (Strid, 1987). The Midwives Section formally supported the Taskforce but both groups agreed to focus on achieving the separate midwifery programmes as a first step and then on reinstating midwifery autonomy before both would put their energies into achieving direct entry midwifery education (Midwives Section 1987d). In the event direct entry and midwifery autonomy were achieved in the same piece of legislation, the 1990 Amendment to the Nurses Act.

The Direct Entry Midwifery Taskforce did a huge amount of work that cannot be underestimated in the eventual achievement of direct entry programmes. In 1988, with funding from the McKenzie Trust Foundation, it distributed a discussion paper and questionnaire about direct entry that served to raise awareness amongst many midwives and others. The 691 replies received indicated strong support for direct entry (NZCOM, 1990). The Taskforce, in association with Carrington Polytechnic and with support from NZCOM, distributed a draft curriculum and further discussion paper in 1990 (Save the Midwives Direct Entry Midwifery Taskforce, 1990). Again there was a huge supportive response. Carrington Polytechnic submitted their direct entry midwifery curriculum to the Nursing Council for approval in 1990 and this was turned down with the Council citing legislative barriers as well as philosophical disagreement with direct–entry midwifery as their reasons (Strid, 1991).

This stance by the Nursing Council concerned Minister of Health Helen Clark who sponsored the Nurses Amendment Bill to reinstate midwifery autonomy. Helen Clark considered that Council was empowered to administer the Nurses Act, not to have a philosophical position on the direction of midwifery education. At the first NZCOM National Conference in Dunedin in August 1990 she told midwives she intended to remove legislative barriers to direct entry midwifery. If the Council still showed no tolerance for such a programme it would *'open up to question whether the Nursing Council is the appropriate body to govern midwifery'* (Clark, 1990, 9-10). During the second reading of the Nurses Amendment Bill Helen Clark introduced legislative changes that would enable the introduction of direct- entry midwifery.

Section 39 of the 1990 Amendment paved the way for direct entry midwifery and two three-year programmes commenced in 1992 under this experimental clause. These were a diploma programme at AIT and a Bachelor of Midwifery degree at Otago Polytechnic. These first two programmes were extensively evaluated over the first four years and in 1996 another three institutions were approved to provide direct entry midwifery programmes. Partway into its first course AIT upgraded its curriculum to a bachelor's degree and there are currently five direct-entry programmes available, all of which award a Bachelors degree.

The significance of direct entry midwifery

Direct-entry midwifery education at last gave the profession the opportunity to prepare midwives for their full scope of practice. Without the pre-requisite nursing registration

midwifery had the opportunity to consolidate its professional identity separately from nursing. The establishment of a pre-registration education programme for midwifery, in parallel to preparation for nursing, clearly identified midwifery as a different career option. The new programmes were able to provide the in-depth focus on midwifery knowledge and practice necessary to produce midwives who were 'specialists' in normal childbirth and with the skills to practise independently of doctors. Midwifery had always supported apprenticeship-type midwifery education and these new programmes combined the best of theoretical educational models with apprenticeship models to facilitate development of evidence-based knowledge from a strong practice base. In creating midwifery academics, direct-entry midwifery education also set the scene for definition and construction of midwifery 'discourse' (Tully, 1999). Midwifery has begun to articulate and record its knowledge base, to carry out original research and to identify what it is that distinguishes it from other professional groups involved in maternity care.

Direct-entry midwifery also provided a framework into which nurses could be incorporated on midwifery's terms. With the rapidly changing practice opportunities for midwives and increasing expectation of independent caseload practice, the one-year separate midwifery programmes could no longer prepare nurses with the necessary knowledge and skills for this new practice context. The one-year programmes for nurses were phased out from 1992 and nurses were admitted to the Bachelor of Midwifery degrees with some credit in recognition of skills and knowledge shared between midwifery and nursing. By combining direct-entry and nursing midwifery students together in one bachelor's level programme, midwifery has cemented itself as a separate profession alongside nursing, preventing any attempts to re-establish midwifery as a post-basic course for nurses.

Direct entry midwifery education has played a critical role in midwifery's consolidation of its status as a profession in its own right. Current and future education developments such as postgraduate midwifery programmes and increasing continuing education programmes are important strategies in strengthening midwifery as a profession. A profession must educate its own members. Not only to ensure that appropriate knowledge, skills and attitudes are taught but also because education is an essential part of professionalisation. It is how we learn to understand our identity as midwives, how we learn what values we share and what standards are expected of us as members of this profession.

Conclusion

In examining midwifery education over the last 100 years similarities and differences can be identified in relation to midwifery practice and the maternity service context. In 1904, as now, midwives provided the majority of the maternity care and had the legislative right to provide this on their own responsibility. Midwives could be businesswomen and maintain some independence. They had status in the community and women and families valued their work. While midwifery faced near demise through the middle of the century because of medicine and nursing's almost successful attempt to take control of maternity services, it managed to survive. Thanks to the political activities of some midwives and maternity consumers midwifery saw resurgence in the latter part of the century that enabled it to claim its professional autonomy and define its scope of practice.

Throughout the century midwifery education has reflected the scope of practice of the midwife and developments in educational theory and practice. Early in the century midwives were prepared for their semi-autonomous role through midwifery 'training' that appears to have relied heavily on experiential learning through clinical practice alongside a more experienced midwife. As the midwife's role reduced to one of 'assistant' midwifery education became more hospital based and task focused. When nurses moved midwifery education into the tertiary education sector as part of the larger shift in nursing education, midwives criticised the limited time available for both theory and practice and decried the loss of opportunity for the development of clinical midwifery skills.

100 years on midwifery education is again separate to nursing. Developments in educational theory and current expectations of midwives mean that the curricula have moved from their task and routine focus in 1904 to emphasise critical thinking and evidence-based practice. The place of women in society is improved and there is increased emphasis on notions of choice, informed consent and individual rights. Advances in science and in research mean that knowledge of childbirth is greater, but the physiological process remains the same and the role of the midwife to support and protect the childbirth process is unchanged across the century.

That midwifery can move from autonomy to near extinction to autonomy again in the space of only 100 years shows that midwifery's existence is not secure. While women will always have babies they do not always have midwives to care for them in childbirth. This is true in other western countries like Canada and America where nurses take on this role. New Zealand women have fought to keep midwives and midwives must now ensure the profession survives to meet the needs of birthing women.

Midwives today have significant advantages over midwives in 1904. Midwifery has a professional organisation to provide leadership and represent midwifery's interests. Midwifery is self-regulating and therefore has control over various aspects of its work such as definition of the scope of practice, entry to the profession, setting of standards, maintenance of competence and discipline. An important mechanism for ensuring that midwives meet these professional expectations is education. Education can assist midwives to understand the lessons of the past, to articulate their scope of practice and philosophy, and to gain the knowledge and skills necessary for practice in today's context. Midwives today must understand the meaning of autonomy and responsibility and partnership with women as these are defining characteristics of the New Zealand midwifery profession in 2005. Education is a key strategy for the survival of the profession.

References

Board of Health Maternity Services Committee. (1979). *Obstetrics and the winds of change.* Wellington: Author.

Board of Health Maternity Services Committee. (1982). *Mother and baby at home: the early days.* Wellington: Author.

Clark, H. 1990, Opening address. *Proceedings of the New Zealand College of Midwives National Conference – Women in Partnership*, Dunedin, August, 17-20.

Coney, S. (1993). Standing in the sunshine: a history of New Zealand women since they won the vote. Auckland: Penguin Books (NZ) Ltd.

Dobbie, M. (1990). *The trouble with women. The story of Parents Centre New Zealand.* Whatamongo Bay: Cape Catley Ltd.

Donley, J. (1986). *Save the midwife.* Auckland New Women's Press.

Hill, A. (1982). *The history of midwifery from 1840 to 1979, with a specific reference to the training and education of the student midwife.* Unpublished MA thesis, University of Auckland.

Kedgley, S. (1996). *Mum's the word. The untold story of motherhood in New Zealand.* Auckland: Random House New Zealand Ltd.

Kennedy, S. & Taylor, A. (1987). *An evaluation of Advanced Diploma in Nursing courses.* Wellington: Department of Education.

Lambie, M. (1956). *My story. Memoirs of a New Zealand Nurse.* Christchurch: N. M. Peryer Ltd.

MacLean, H. (1932). *Nursing in New Zealand. History and reminiscences.* Wellington: Tolan Printing Company.

Mein-Smith, P. 1986, *Maternity in Dispute. New Zealand 1920 – 1939.* Historical Publications Branch Department of Internal Affairs, Wellington.

Midwives Act (1904) *New Zealand Statutes,* Wellington: Government Printer.

Ministers of Health, Education and Women's Affairs. (1987). *Press release: Changes to midwife training 7/12/87.*

National Midwives Section. (1984). *Report of the working party looking into education for the role, scope and sphere of practice for the midwife in New Zealand.* Wellington: NZNA.

National Midwives Section. (1987). *Minutes of Annual General Meeting 23/9/87.* unpublished.

Neill, J.O.C. (1961). *Grace Neill. The history of a noble woman.* Christchurch: N.M. Peryer Ltd.

New Zealand College of Midwives. (1990). Direct entry midwifery update. *Newsletter, 2,* (5), February, p.11.

New Zealand Nurses Association. (1981). *Policy statement on maternal and infant nursing.* Wellington: Author.

New Zealand Nurses Association. (1984). *Nursing education in New Zealand. A review and a statement of policy.* Wellington: Author.

New Zealand Nurses Association. (1987). *An evaluation of the Advanced diploma in Nursing courses (Department of Education). What is to be done? NZNA comments on the report.* Unpublished paper.

New Zealand Nurses' Association. (1989). *Midwifery Policy Statement.* Wellington: Author.

Nurses and Midwives Registration Act (1925), *New Zealand Statutes,* Wellington: Government Printer.

Pairman, S. (2002). Towards self-determination: the separation of the midwifery and nursing professions in New Zealand. In E. Papps (Ed.) *Nursing in New Zealand. Critical issues; Different perspectives.* Auckland: Pearson Education New Zealand Ltd.

Papps, E. (1997) *Knowledge, Power and Nursing Education in New Zealand. A Critical Analysis of the Construction of the Nursing Identity.* Unpublished Doctoral Thesis, University of Otago.

Papps, E. & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: a Foucauldian perspective.*

Parkes, C. M. (1991). The impact of the medicalisation of New Zealand's maternity services on women's experience of childbirth, 1904-1937. In L. Bryder (Ed). *A healthy country. Essays on the social history of medicine in New Zealand,* Wellington: Bridget Williams Books.

Rattray, J. (1961). *Great days in New Zealand nursing,* Wellington: George Harrop & Co. Ltd.

Save the Midwives Direct Entry Midwifery Taskforce. (1990). Direct entry to midwifery. *Save the Midwives Newsletter, 23,* May, 12-20.

Shepherd, M. (1989). *Some of my yesterdays. The autobiography of Marion Shepherd.* Invercargill: Craig Printing Co. Ltd.

Strid, J. (1987). Maternity in revolt, *Broadsheet, 153,* pp.14-17.

Strid, J. (1991). The need for ongoing discussion and debate. *Maternity Action and Save the Midwives Newsletter, 26,* Autumn, p.1.

.....Tully E. (1999). Doing professionalism differently: negotiating midwifery autonomy in Aotearoa/New Zealand. Unpublished doctoral thesis, University of Canterbury, New Zealand.

Wassner, A. (1999). *Labour of love. Childbirth at Dunedin Hospital 1862 – 1972,* Dunedin: Author.

Part Five: Midwifery Regulation

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Part Five of this thesis explores New Zealand midwifery's fourth key professionalising strategy, self-regulation, where this self regulation is designed and executed within professional frameworks developed by midwives for midwives. As explored in Part One of this thesis, professional projects seek both autonomous and heteronomous means of professionalisation to achieve occupational closure or jurisdiction over an area of work (Larson, 1977; Abbott, 1988; Witz, 1990). Autonomous means of closure are those which are defined or created by professional groups themselves, while heteronomous means of closure are those chiefly defined or formed through other social groups. These may be, for example, government Acts or regulations. Midwifery's autonomous means of closure are institutionally located in the New Zealand College of Midwives and in the schools of midwifery and the polytechnics and universities in which they are located. These are expressed through midwifery's mechanisms for education and professionalism. Midwifery's heteronomous means of closure are institutionally located in the State and are expressed through State registration processes for the regulation of midwifery. Until 2003 the agent for these heteronomous means of closure was the Nursing Council of New Zealand. Therefore, although midwifery was recognised as an autonomous profession through the 1990 Nurses Amendment Act, it was not fully self-regulating until the establishment of the Midwifery Council of New Zealand in 2003.

In Part Five of this thesis I first examine how the New Zealand College of Midwives initially mediated the regulatory processes of midwifery in the absence of a separate regulatory authority for midwifery. Next I trace the establishment of the Midwifery Council of New Zealand, and finally I examine how the Midwifery Council is establishing its regulatory processes within midwifery professional frameworks. The roles of the Midwifery Council of New Zealand and the New Zealand College of Midwives are separate but complementary. It is through the coherence and consistency of their separate structures that New Zealand midwifery now operates within an integrated professional and regulatory framework that recognises and supports midwifery as a profession in partnership with women.

Part Five of this thesis is of necessity briefer than the other accounts of professionalising strategies. While it has always been the intention of midwifery to achieve full self-regulation through its own regulatory authority, this achievement is very recent. The Midwifery Council was established in 2003 but regulatory responsibility for midwifery was only transferred from the Nursing Council to the Midwifery Council on the 18th September 2004. Thus the Midwifery Council has been in operation for only ten months at the time Part Five of this thesis is being written. Of necessity, therefore, Part Five of this thesis can only provide an overview of the regulatory processes that the Midwifery Council is developing, and discuss the beginning understandings the Council has of its role in relation to wider issues of public safety and midwifery professionalism. As the inaugural Chair of the newly established Midwifery Council of New Zealand, I have an insider view of the policies and processes we are developing and I play a leadership role in establishing midwifery's regulatory framework in ways that protect public safety and also increase midwifery professionalism. The two are not mutually exclusive; indeed I argue that it is by strengthening midwifery professionalism that the safety of women and babies in midwifery can be maximised.

I begin by providing background to the establishment of the Midwifery Council and then move to discuss its developing regulatory framework and some of the policies it is putting in place to enhance professionalism. In particular I will discuss the Midwifery Council's Recertification Programme as an example of how the Council is integrating its regulatory framework with the College's professional framework.

Self-regulation within midwifery professional frameworks

Background to self-regulation

As discussed in Parts Two, Three and Four of this thesis, midwifery has been recognised by the State as an occupation since 1904 when the Midwives Act was passed and registration processes for controlling entry to midwifery practice were first established. Initially these

processes were mediated by medicine and the 1904 Act gave powers of supervision and surveillance to doctors by establishing a doctor as the Registrar of midwives, to implement the registration processes, and by giving District Health Officers (also doctors) powers to supervise midwives, to suspend midwives in order to prevent the spread of infection and to investigate charges of professional misconduct against midwives (Midwives Act, 1904; Papps & Olssen, 1997).

From 1925 midwifery was combined with nursing under the Nurses and Midwives Registration Act which established the Nurses and Midwives Board to implement the provisions of the Act. These provisions included registration of midwives; setting the curriculum for midwifery training programmes through the St Helen's hospitals; and carrying out disciplinary functions as necessary (Nurses and Midwives Registration Act, 1925).

By 1971 medicine had asserted control over the provision of maternity services in New Zealand through a series of demarcationary strategies (Witz, 1992) that sought to bring midwifery under medical supervision in the subservient role of 'obstetric nurse'. This demarcationary strategy on the part of medicine gained legal sanction through the 1971 Nurses Act which required midwives to work under the supervision of doctors and removed the name 'midwife' from the title of the legislation, thereby reinforcing midwifery's loss of identity as a discipline that was separate to both medicine and nursing. Medicine was assisted by the nursing profession in its aim of restricting autonomous midwifery practice, because nursing was trying to build its own specialty of 'obstetric nursing' as an adjunct to medical care in the provision of maternity services.

Midwifery used dual closure strategies (Witz, 1992) in response to medicine's demarcationary strategy. These consisted of simultaneous usurpationary resistance to medical control and medical definition of midwifery's work, with its own exclusionary strategy of occupational closure to regain midwifery autonomy over 'normal' childbirth and re-establish its identity as a separate discipline to nursing and a profession in its own right.

It was the interplay of a number of specific and historically bounded factors that led to the eventual success of midwifery's exclusionary strategy of occupational closure. These factors included the collaborative political activity of maternity consumer activists and midwives; a government agenda that gave priority to women's equity issues; the report of the Cervical Cancer Inquiry (1988) that raised issues of patient's rights, choice and informed decision-making; and a social climate in which the traditional power of professions was being challenged and reshaped (Committee of Inquiry, 1988; Haug, 1975; Barnett, Barnett & Kearns, 1998; Colyer, 2004; Health Workforce Advisory Committee, 2005).

Although the 1990 Nurses Amendment Act reinstated midwifery autonomy it left the regulatory control of midwifery with the Nursing Council of New Zealand as regulatory provisions were part of the substantive Nurses Act 1977 and were not covered in the 1990 amendment. It had always been an objective of midwifery to have its own specific legislation and thereby achieve full professional autonomy as a self-regulating profession (McKendry and Langford, 2001). As is recorded in the portfolio that accompanies Part Five, midwifery worked to achieve a Midwives Act for many years, first through the Midwives Section of the New Zealand Nurses Association and then through the New Zealand College of Midwives. This desire to have our own legislation, separate to nursing, was even more acute after the 1990 Amendment as midwifery was frustrated by its continued control by nursing through the regulatory activities of the Nursing Council.

However, the 1990 Amendment did provide a place on the Nursing Council for representation by the College and as is recorded in the portfolio for Part Five of this thesis, those midwives who took on this role from 1990 to 2004 managed to bring about a number of important changes within the Nursing Council. Chief among these was the policy decision in about 1998 to change the working title to Nursing and Midwifery Council despite the Act specifying the name of the Council as the Nursing Council (Kilpatrick, 2003).

As a result of the College membership on Council and the later philosophical shift to recognise nursing and midwifery as separate and distinct professions, the College entered into a partnership with the Council to develop the regulatory policies and processes that were specific to midwifery. These included setting the competencies for entry to the register, setting the standards for pre-registration midwifery education programmes, and developing the proposed initiative for competence-based practising certificates (which implementation was overtaken by changes in legislation).

Therefore, although the College was the professional organisation for midwifery it had an important influence on the regulatory processes for midwifery, which set the scene for later developments by the Midwifery Council of New Zealand.

The Health Practitioners Competence Assurance Act 2003

As discussed in the portfolio pieces of Part Five, the Midwifery Council of New Zealand was established with the passing of the Health Practitioners Competence Assurance Act (HPCAA) in December 2003. This was an innovative piece of legislation as it brought together all regulated health professions, including medicine, under a single piece of legislation, repealing all previous separate legislation. The HPCAA provides generic regulation which is then enacted by responsible authorities for each profession. Thus the Midwifery Council of New Zealand stands alongside the Medical Council of New Zealand, the Nursing Council of New Zealand and a number of other professions such as occupational therapy, physiotherapy, dentistry, psychology, and dietetics.

While the legislation is generic, there is considerable discretion for professions to develop policy and processes to implement the legislation in unique ways. The HPCAA sets out the functions of the various professional Councils, or as they are termed in the Act, Responsible Authorities. In summary each Authority is required to:

- Maintain a public Register
- Authorise registration
- Set standards of clinical, cultural and ethical competence

- Monitor and accredit educational institutions, programmes and degree courses
- Review and promote the competence of practitioners
- Issue Annual Practising Certificates (APC)
- Notify appropriate persons or bodies, where the practice of a health practitioners may pose a risk of harm to the public; and
- Establish health and disability procedures for practitioners whose health or habits are affecting their practice (HPCAA, 2003)

Each Authority is also required to establish a 'scope of practice' for the profession it regulates and identify any health services which are to be termed 'restricted activities' and thus only able to be performed by health practitioners who are competent to practise such activities. The HPCAA gives the Midwifery Council a wide scope to establish Professional Conduct Committees and Competence Review Committees to investigate and review the conduct and competence of any midwife. If competence concerns are identified the Council may require a midwife to undergo a competence programme to ensure she is practising to safe and reasonable standards and may impose restrictions or conditions on the midwife's practice to ensure protection of the public while improving her standard of practice.

The HPCAA also divides the disciplinary and regulatory functions of Councils by establishing the Health Practitioners Disciplinary Tribunal (HPDT) with separate responsibility for hearing all charges of professional misconduct against all professionals. The HPDT has its own chair and deputies, but constitutes a tribunal panel of one lay representative and three professional representatives, of the relevant professional group, from an appointed pool of tribunal members. Therefore, disciplinary hearings are still heard by the profession, although in a separate process to the standards and competence focus of the HPCAA regulatory authorities.

Midwifery and Nursing as separate professions

The HPCAA clearly separates the two professions of nursing and midwifery by establishing a Council for each. While this move was met with excitement for most

midwives it raised issues of identity for some midwives and nurses, particularly those midwives who hold both registrations. Because the HPCAA requires each profession to define its scope of practice and competencies and then to ensure that each member of the profession maintains competence in that scope in order to continue to practice, midwives and nurses have had to decide, for the first time, whether they wanted to maintain competence in the midwifery scope or the nursing scope (Campbell, 2004). While registration is lifelong (unless removed through a disciplinary process), the ability into practise is now dependent on holding an Annual Practising Certificate, and this means participating in the relevant recertification programme for that scope of practice.

Therefore in 2005 in applying for an APC for 2005/6 midwives with dual registration had to decide if they were going to practise midwifery or nursing. Once that decision is made the midwife or nurse completes the relevant recertification requirements. If they wish to later move back into nursing or vice versa, they will have to meet whatever 'return to practice' requirements are in place for that discipline. Of course it is possible to hold both APCs but this means participating in both recertification processes and paying the associated dual fee.

The Midwifery Council of New Zealand

The establishment of the Midwifery Council of New Zealand (MCNZ, the Council) in December 2003 was an historic event that provided final recognition that midwifery is a profession in its own right. In September 2004 the Midwifery Council took over all regulatory functions and responsibilities from the Nursing Council.

The Midwifery Council is comprised of six midwives and two lay members and its focus is to protect the public and ensure they receive safe and competent midwifery care. It does this by carrying out a number of statutory functions, outlined above, that came into force on 18 September 2004. The first Council membership consists of midwives with backgrounds in caseload practice, rural midwifery, core-facility midwifery, primary unit midwifery, secondary/tertiary facility midwifery, and education ("Members of Midwifery Council", March 2004). Two midwives are also Maori. The two lay members come with a long

history of consumer involvement in the Homebirth Association and Parents Centre New Zealand. Both have previously been consumer members of the National Committee of the College. One midwife member is currently the President of the College and all but one of the midwives are active member of the College.

Midwifery Scope of Practice and Competencies for Entry to the Register of Midwives

One of the first activities of the Council was to define its scope of practice. The Council carried out an extensive consultation for both the scope and the competencies for entry to the profession. A consultation process was undertaken to ratify the New Zealand College of Midwives adaptation of the International Confederation of Midwives definition of a midwife and the Competencies for Entry to the Register that were developed collaboratively between the Nursing Council and the College in 1996 (NZCOM 1993, 2002; NCNZ, 1996). The Council received 457 responses from individuals and groups and a number of small changes were made to both the scope[iv] and competencies[v] to improve clarity, emphasise midwives responsibility to enhance the normal physiological process of birth and to make clear that midwives could continue to care for women with complications but that they would do so in collaboration with other midwives and other health professionals (Midwifery Council of New Zealand, 2004a).

Importantly the Council clarified the relationship between the Midwifery Scope of Practice and the Competencies for Registration. The Scope provides a broad statement of the boundaries of what a New Zealand midwife can do on her own professional responsibility. It provides a legal definition of New Zealand midwifery practice. It does not mean that every midwife must practise the full scope all of the time. Rather, it is expected that all midwives can demonstrate that they are able to practise to the full scope, even if their daily practice is more restricted. The Midwifery Scope of Practice reflects what the public expects from anyone holding the title of 'midwife' (Midwifery Council of New Zealand 2004a)

The Competencies for Entry to the Register of Midwives provide the detail of the skills, knowledge and attitudes expected of a midwife to work within the Midwifery Scope of Practice. Where the Midwifery Scope of Practice provides the broad boundaries of midwifery practice, the competencies provide the detail of how a registered midwife is expected to practise and what she is expected to be capable of doing. These are minimum competence standards required of all midwives who register in New Zealand. Again, not all midwives will necessarily demonstrate all competencies all of the time in their everyday practice. However, the Council requires all midwives to make an annual declaration that they are able to meet these competencies (Midwifery Council of New Zealand 2004a)

Other policy development

Since its inception in December 2003 Council has also developed policy and processes for registration of midwives from New Zealand and from overseas; assessment of ongoing competence; the issuing of Annual Practising Certificates; competence review; and its health and disability processes (Midwifery Council of New Zealand, 2004b). It has also spent considerable time providing information to midwives, consulting with midwives, consumer organisations and other stakeholders and clarifying for midwives the role of Council in relation to the College. This relationship is very important because it provides the basis for the development of an integrated regulatory and professional framework for New Zealand midwifery that both protects the safety of women and babies and enhances the professionalism of midwifery. I have taken an active role in the construction of all of these documents.

Relationship between New Zealand College of Midwives and Midwifery Council

Although they are separate organisations, the roles of the Council and the College are complementary. The Council provides the regulatory framework within which midwives must practise and it sets the minimum standards required for public safety. The College provides the professional framework in which midwives practise and it aims to develop and

support high standards of midwifery practice. Both organisations have an interest in ensuring that the regulatory processes for midwives are integrated in a professional framework and that appropriate standards of midwifery practice are maintained so that the public can be assured of safe and competent midwifery care. Appendix four presents a diagram that shows the interface of these professional and regulatory frameworks. The central mechanism that brings these two frameworks together is the College's process of Midwifery Standards Review (MSR). The Council now requires that all midwives, both case loading and core midwives, must complete MSR as part of its recertification requirements, whereby midwives demonstrate that they remain competent to practise midwifery and therefore eligible for an APC. This Recertification Programme is a key mechanism for enhancing midwifery professionalism and thereby protecting the safety of women and babies, and I will discuss it next.

Recertification Programme

An important feature of the HPCAA is the emphasis it places on the requirement for health professionals to demonstrate their ongoing competence in order to practise. It is no longer acceptable to the public, and therefore to government, that professionals continue to practise on the basis of a competence assessment completed when they first registered and entered the profession. Midwifery is possibly the only profession that had previously developed a mechanism for ongoing competence, its Midwifery Standards Review process, but this was only compulsory for case loading midwives.

The HPCAA requires Responsible Authorities to establish processes for assessment of ongoing competence and to use this to determine whether or not to issue an APC so the professional can continue to practise. The Midwifery Council's Recertification Programme is one of the two portfolio pieces for Part Five and so I will not describe it in detail here. Its main features are that in each three-year period it requires a midwife to show that she has worked in the full scope of practice, sufficient to maintain competence as measured by the Competencies for Entry to the Register. In addition she must complete a designated amount of compulsory and elective continuing education, a designated amount of professional

activity and participate in Midwifery Standards Review either annually or every three years depending on her type of practice.

The Recertification Programme is just beginning to be implemented as I write this section of the thesis and the first series of compulsory 'Technical Skills Workshops' have just been completed. While the Recertification Programme may appear prescriptive, it is a significant mechanism for raising basic standards of midwifery practice and encouraging midwives to take more professional responsibility for continuing education and the development of knowledge and skills. It is, therefore, a mechanism for enhancing midwifery professionalism and it is the Council's expectation that as this programme becomes established and as all midwives participate, that we will see demonstrable changes in the way that some midwives understand themselves as members of a profession. This is yet to be seen, but early feedback about the Technical Skills Workshops indicates a level of excitement and a building sense of identity as midwives (Personal communication, Norma Campbell, June 2005).

Discussion

As has been described, the recent establishment of the Midwifery Council under the HPCAA finally separates midwifery from the nursing profession and establishes it as a self-regulating autonomous profession with equal standing in law to all other regulated health professions in New Zealand.

The establishment of the Midwifery Council and its processes have facilitated midwives to claim their identity as midwives, separate to nurses; recognise and claim the midwifery scope of practice and demonstrate that they are competent in it, even though their daily practice may reflect only aspects of this scope; recognise the entry level expectations for the profession and assess themselves against these in order to demonstrate continuing competence; and enhance their professionalism through participation in the Recertification Programme. Of these it is this Recertification Programme that is of key importance.

By placing the College's Midwifery Standards Review process as the central mechanism for demonstrating ongoing competence, the midwifery profession through the Council and the College is upholding an important process for both partnership and accountability to women. By contrast, the newly regulated midwifery profession in Ontario, Canada, has expressed concern that:

> *The establishment of a bureaucratic organisation to regulate midwifery in place of midwifery consumers, albeit in their interest, may serve to distance midwives from their clients* (Bourgeault, 2000).

It is therefore imperative that midwifery ensures that Midwifery Standards Review is integrated in both its regulatory and professional frameworks. This is a major strength of the profession and it provides a mechanism for midwifery partnership to be expressed in regulatory processes as well as existing professional processes.

This concludes Part Five and I will now move on to discuss the portfolio for Part Five

Linking the portfolio

The next section of Part Five of this thesis provides two pieces of work that more fully explicate aspects of this final key professionalising strategy, self-regulation through midwifery professional frameworks

These two pieces of work consist of a chapter for the book I am writing with Karen Guilliland and a policy document of the Midwifery Council of New Zealand. I will discuss these in more detail in the following section.

Part Five: Midwifery Regulation Portfolio

List of portfolio pieces

Pairman. S. & Guilliland, K. (forthcoming). Midwifery regulation beyond 1990. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

Midwifery Council of New Zealand. (2005). *Recertification Programme: competence-based practising certificates for midwives. Policy document.*

Locating the work.

These two pieces are works I have undertaken in relation to midwifery regulation through the period of study for this Professional Doctorate. Congruent with a 'professional doctorate' these works are a result of my professional practice as a midwifery leader and as the inaugural Chair of the Midwifery Council of New Zealand.

The first piece is another chapter written jointly with Karen Guilliland for our forthcoming book on New Zealand midwifery. It is a personal reflection of our experiences on the Nursing Council of New Zealand, as well as a description of the College's activities in bring about the establishment of the Midwifery Council through the Health Practitioners Competence Assurance Act 2003.

The second piece is a policy document of the Midwifery Council of New Zealand, written by me but on behalf of the Council and as a result of consultation and discussion with the wider midwifery profession and other stakeholder groups. This document sets out the Council's policy and process for the recertification requirements of midwives, whereby they demonstrate their ongoing competence to practise. It is a key policy in the Council's development of a regulatory framework that integrates with midwifery professional frameworks.

Pairman. S. & Guilliland, K. (forthcoming). Midwifery regulation beyond 1990. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

[Note this is an unedited version prior to publication and may change during the editorial process]

Chapter Ten: Midwifery Regulation beyond 1990

The Nurses Amendment Act 1990 was the first of several legislative changes over the next 15 years that impacted on midwifery. Changes were made to the organisation of health services through the 1993 Health and Disability Services Act and the Public Health and Disability Services Act 2000. Consumer complaints mechanisms were further developed in 1994 with the appointment of a Commissioner under the Health and Disability Commissioner Act and the development of a Code of Health and Disability Services Consumers Rights. There was ongoing review of the Nurses Act 1977 that was eventually discontinued with the passing of the 2003 Health Practitioners Competence Assurance Act that repealed all individual health practitioner legislation and replaced them with a generic 'omnibus' singe piece of legislation.

Health and Disability Commissioner Act 1994

While the original Health Commissioner Bill was introduced to Parliament in 1990 to provide a framework for protecting the rights of health consumers, it had a long and difficult journey to law. A number of changes were made through Supplementary Order Papers and the Bill was not even sent to Select Committee until 1993. Consumer activists Sandra Coney, Phillida Bunkle, Judi Strid, Lynda Williams and others, along with the College's support, were instrumental in ensuring that the Bill met the needs of health consumers. Important aspects were the linkages between this legislation and the various pieces of health professional legislation. The relationships between legislation were tested in the Medical Practitioners Act 1994. These relationships then provided a framework for later development of the Health Practitioner Competence Assurance Act.

Review of the Nurses Act 1977

The Midwives Section and then the New Zealand College of Midwives gained considerable experience and familiarity with the issues of regulation through our involvement in submissions to the review of the 1977 Nurses Act that began in 1989. The Department of Health with input from the Working Group on Occupational Regulation consulted extensively through 1989 with interested organisations about a review of the Nurses Act 1977. This consultation culminated in a draft policy paper in 1990 that was to set the foundation for a revised Nurses Bill.

Midwifery had campaigned for a separate Midwives Act from about 1985, and all our submissions focused on having midwifery defined in legislation. Indeed, we appeared to have convinced the Working Group on Occupational Regulation that a definition of the scope of midwifery practice should be included in a revised Act. The Working Group noted

the pressure from midwives to have the specialties of their practice recognised and agreed that, *"the definition should reflect a primary health care philosophy and reflect the Ottawa charter and article two of the Treaty of Waitangi"* (Department of Health, 1990, p.8). The Working Group suggested the following definition as the basis for discussion.

> *Midwifery practice or the practice of midwifery means representing oneself as a registered midwife, while carrying out the practice of those functions which, in partnership with a client, have as their objective primary health care, promotion of health, prevention of illness, alleviation of suffering, restoration of health and maximum development of health potential and without restricting the generality of the foregoing includes ...'* (Department of Health, 1990. p.9).

The rest of the definition went on to describe the ICM definition of a midwife.

While the influence of nursing was still apparent in this proposal it was an exciting step forward for us to see the take up of the primary health, partnership approach. We were enormously relieved and it forever changed our relationship with the Department of Health. From then on we were seen as a separate discipline with credibility and it was easier to contribute in a more pragmatic rather than philosophical way to the development of the Bill.

Helen Clarks' amendment in 1990 interrupted this review process, as did the change in government that year, and the review of the Nurses Act was delayed.

Nurses and Midwives Bill

Nevertheless, once the 1990 Amendment was passed a full review of the Nurses Act 1977 was still considered necessary. The new Minister of Health, Katherine O'Regan, continued the work by initiating drafting proposals for a Nurses and Midwives Bill that drew on the recommendations of the 1990 draft policy paper discussed above. As the review unfolded it became clearer to both the Department of Health and nursing that midwifery's separate identity should be recognised and it was proposed that the title of the Nurses Act be changed to the Nurses and Midwives Act. We reluctantly agreed simply in the interests of goodwill and to make some headway. The agreement by nursing that that the new Act would be named the Nurses and Midwives Act was a significant step forward. Our intention was that midwifery would have its own processes within the combined Act.

Collaboration

The whole approach of government and Minister of Health, Katherine O'Reagan to reviewing the Nurses Act was unprecedented. Serious efforts were made to explore the views of the professions as legislation was drafted. This approach helped midwifery and nursing to work together more effectively.

From 1993 to 1996 the College collaborated with the Department of Health and all key nursing groups to develop a Nurses and Midwives Bill based on the Medical Practitioners Bill. This 'Umbrella Group" was made up of the Nursing Council, the NZNO, College of Nurses, Nurse Educators in the Tertiary Sector, National Council of Maori Nurses, Nurse Executives and the New Zealand College of Midwives. As part of this group midwifery also made a significant contribution to the framework for nursing. Sally Pairman and Elaine

Papps drafted the first Nurses and Midwives Bill proposal that was submitted to the Department of Health by this group.

Review of Health Sector Occupational Regulation

The Nurses Act review was once again overtaken when in 1997 the government launched a comprehensive and wide-ranging review of all occupational legislation. We had some anxieties about this occupational review as it was primarily driven by economic reform based on deregulation and competition. The terms of reference for the review were

> *"to examine the continued need for such regulation having regard to the risks to consumers from incompetent practice and, if there was a continuing need to do so, examine whether the principles inherent in the Medical Practitioners Act 1995 provided a suitable basis for regulating these occupations"* (Department of Health,1997, p.1).

In this review process the New Zealand College of Midwives argued firstly for the continued regulation of midwifery and secondly for separate legislation and we submitted our own draft legislation for a Midwives Act. The continuing need for regulation of midwifery was recognised and midwifery was included in ongoing discussions about a new legislative framework. For a time this framework was referred to as the 'Omnibus Bill' as it would provide the same regulatory framework for all health professional groups. The experience of meeting with all the other health professional groups was extremely valuable for us in that it deepened our understanding of professionalism and accountability and the specific role of regulation in influencing and guiding these.

The Omnibus Bill was to be modelled on the Medical Practitioners Act framework. We took the opportunity to strongly and adamantly promote the view that any omnibus legislation must include medicine if all other health professional groups were not to be second-class citizens. We had learnt the lessons in relation to equality during our campaign for the Nurses Amendment Act and the subsequent maternity benefit funding negotiations. We informed the Ministry and ministers that midwifery would refuse to be involved in any legislation that did not include medicine. While some allied health profession groups were slow to realise the potential effect of separate legislation, others like dentists, optometrists, podiatrists, chiropractors, supported our stance.

Health Practitioners Competence Assurance Act (HPCA)

In the event the government changed again and the omnibus bill never eventuated. However, the work was not lost as much of it provided the basis for a new proposal for a Health Practitioners Competence Assurance Bill. The significant difference between the HPCAA as compared with the omnibus bill was that the Labour Government did not support deregulation. The HPCAA was also intended to address a number of very public cases around professional incompetence such as the Bottrill case where a lone pathologist was misreading cervical smears, and the Parry case where a gynaecologist failed to diagnose cervical cancer. The HPCAA Bill was to replace the current 11 health occupational statutes; most of which were old, prescriptive and non responsive to a changing health sector. They were not seen to meet the needs of the public, the regulators or the professions. The HPCAA would provide a single regulatory framework for all health professions but would establish separate registering authorities. The focus of the HPCAA

Bill was on each profession defining its own scope of practice, establishing mechanisms to ensure continuing competence for all health practitioners and aligning the professional disciplinary procedures through one single body, the Health Practitioners Disciplinary Tribunal.

There was now a mechanism for midwifery to separate midwifery regulation from nursing. It was Annette King, then Minister of Health, who drew our attention to the potential for midwifery under this proposed legislation. While the work of the previous 15 or so years meant that government, the Ministry of Health and nursing now accepted that midwifery and nursing were separate, it was Annette King who ensured that this could happen through the HPCAA. She never wavered from the concept of a separate Midwifery Council, even when some individual nurses and midwives told her she shouldn't support such an idea. Like Helen Clark, Annette King also understood the primary health nature of midwifery. She went on to champion the Primary Health Strategy and Primary Health Organisations in an effort to move primary health services back into the community.

The College suggested to other allied health professional groups and latterly medicine and nursing that a combined collaborative approach to addressing the Bill would best use their combined efforts on aspects that were of mutual concern. For example, the proposal for mandatory reporting of colleagues suspected of incompetence was not supported by any of the professions. Mandatory reporting was considered to undermine a supportive and educative approach as the first line to addressing competence issues. There was also an effort to strengthen the natural justice elements of many clauses, which often meant double or triple jeopardy for the individual practitioner.

A concern of both the College and the Nursing Council was the separation of the discipline and registration functions. It was thought that a single multi-disciplinary tribunal focused only on discipline could be isolating for the tribunal members, as they would not be exposed to the wider educative and competence aspects of the Council's work which add balance and perspective to consideration of disciplinary matters. There was also the issue of costs for smaller health professional groups who, unlike medicine and nursing, did not have the numbers of practitioners to easily support high cost structures such as the separate tribunal. Smaller professions would be required to contribute to the set up and ongoing costs of a separate tribunal structure that would mostly hear cases from medicine and nursing.

Another joint concern of nursing and midwifery was the concept of restricted activities whereby certain activities were to be restricted to registered health practitioners who had them in their scope of practice, in order to protect the public from the risk of serious or permanent harm. We could always see the difficulty in defining the restricted activities and believed that this would be better managed through the scope of practice mechanisms. An example from the initial list proposed demonstrates the complexity of trying to restrict activities to certain groups.

> *Invasive procedures, including surgical or operative procedures on, in or below the surface of the skin, mucus membranes or teeth"* (Ministry of Health, 2004).

Under this definition the College argued that a woman would need to be a registered health practitioner in order to insert a tampon, and even then only if it was in her scope of practice.

Midwives experiences on Nursing Council

In making its submission to the HPCAA Bill the College drew on the experiences that a number of its members had previously had on the Nursing Council of New Zealand. Since 1990 the College had members on the Nursing Council. Karen was the first appointee after the Nurses Amendment Act and served three years. Even though the Council's submissions on the Act stated it did not have a position on whether midwifery should be a separate profession, it was fairly clear that individuals on Council at the time were not supportive. In Karen's experience it was extremely difficult to get information on anything that involved midwifery as little made it through the system and if it did the minutes either didn't record it or they were unrecognisable. Despite requesting and getting Council's approval to see any correspondence related to midwifery it was never passed on. At one stage when discussing midwifery education Karen was so outraged at the recorded minutes she demanded to listen to the tapes and subsequently rewrote the minutes to reflect the actual conversation. All this did of course was to sideline her even further. Some years later and much wiser she wishes she had sought out some resolution conflict training to help her understand how to deal with the passive-aggressive nature of the meetings without becoming so emotionally disturbed by the experience. This sense of seeing the world differently from the rest of the Council also occurred during disciplinary hearings, where the midwifery perspective favoured mediation and education while the response from nursing in the main seemed to be punitive. The constant exception was psychiatric nurse Michael McPherson whose more liberal, natural justice approach around mental health issues was also often misunderstood. Some individual Council members while personally supportive were not always able to follow that support through in the open forum especially when they couldn't quite bring themselves to agree that midwifery was not nursing. This oppressed and oppressive behaviour was of course rampant throughout nursing and midwifery and is still a constant companion to those nurses and midwives who speak out or advocate strongly for alternative approaches to the status quo.

Sally experienced similar issues some seven years later in 1997 when appointed to Council. She served a three-year term and was Deputy Chairperson for most of that time. The main difference for Sally was that she worked with a supportive Chairperson, Judy Kilpatrick, and even though they had stormy disagreements their arguments were about debating principles and finding consensus where possible rather than personal attacks. Unlike Karen and Jackie Gunn who were both the only midwives on Council during their terms, Sally had other midwives on Council with her. Sue Bree took over from Jackie Gunn in 1996 and Cheryl Benn and Sally were both appointed in 1997. Under Judy's leadership this Council really worked as a Nursing and Midwifery Council. For the first time policy and processes were established separately for nursing and midwifery. It was during these years that the Council involved the New Zealand College of Midwives more fully and together the organisations developed a policy of collaboration and partnership on midwifery policy. The work done in these years included development of the competencies for entry to the register, the draft competence-based practising certificate process, adoption of the College's midwifery education framework, and further development of the Council's standards for pre-registration midwifery education.

Sandy Grey and Jean Patterson were appointed in 2000 and remained on Council through the transition to the Midwifery Council to ensure that midwives already in the disciplinary process of the Nursing Council had midwifery involvement in any decision-making. Hope Tupara was appointed in 2002 but was transferred to the Midwifery Council in 2003. During their terms both Sandy and Sue made long-term commitments to their appointments to the Preliminary Proceedings Committee (PPC) of Council. Sue was Chairperson of PPC for three years.

In 2003 the College held a meeting of all previous midwife members of Nursing Council in order to discuss the HPCAA and potential membership of the Midwifery Council. This meeting provided an opportunity to debrief for most of these midwives who had never had the opportunity to talk about their personal experiences as members of Council. An overarching theme for all was the very real antagonism they had experienced from most nurse members of Council towards midwifery. This antagonism was always present just under the surface and came to life whenever a midwifery issue was discussed. It seemed that most nurse members of Nursing Council perceived that midwife members had a conflict of interest whenever a midwifery issue arose; but the nurses did not perceive themselves as having any conflict at all, regardless of the position they held in the health system. For example, even as late as 2004 Sandy Grey and Jean Patterson were denied a voice in Council's decisions about seeding money allocation to the new Midwifery Council. They did not receive correspondence and were excluded from meetings on the grounds that they had a conflict of interest. This despite having been appointed by the Minister specifically to bring their expertise on midwifery issues during the change over to the Midwifery Council.

There were rare individual exceptions in nurses such as Michael McPhearson, Isobel Sherrard and Judy Kilpatrick, who fully understood their governance role and how this related to other professional roles. However, nursing could also turn against its own and Judy Kilpatrick played a price for her innovative and dynamic leadership, as she was the first and only nurse, to our knowledge, to be actively campaigned against by the New Zealand Nurses Organisation (NZNO) in an effort to remove her from Council and thereby dissipate her influence.

Establishing the Midwifery Council

The Health Practitioners Competence Assurance Act (HPCAA) was passed into law on 18 September 2003. It replaced the Nurses Act 1977 and Amendments and 10 other pieces of health professional regulatory legislation. The Minister of Health, Annette King, appointed the first Council members on 16th December 2003 and the Midwifery Council took over the regulatory functions for midwives from the Nursing Council on the 18th September 2004

The principal purpose of the HPCAA is to protect the health and safety of the public by providing ways to ensure that health practitioners are competent and fit to practice their professions (s.3). In summary the HPCAA aims to:

- Provide consistent accountability across the health professions. All previously regulated professions (such as midwives, physiotherapists, doctors, dentists, nurses, occupational therapists) plus a few new ones – osteopaths, dental hygienists, and dental therapists –

are now covered by the same legislation, but each has its own regulatory authority to administer the Act. This makes it easier for the public to understand.

- Establish the mechanisms for determining scopes of practice and qualifications for each health practitioner. This is so the public can understand what health service each registered practitioner is qualified to provide.
- Provide systems to ensure that health practitioners are registered and don't operate outside their own scope of practice.
- Provide systems to ensure that health practitioners maintain their competence and fitness to practice after registration
- Restrict specified activities to particular classes of health practitioner. Certain activities posing a greater potential risk of harm to the public will be restricted to those health professions able to perform those tasks within their scope of practice. Anyone else attempting to perform them will be breaking the law and can be prosecuted.
- Provide a consistent process for complaints and discipline across the health professions.

The College gave considerable thought to the midwives and the women it would nominate to the first Midwifery Council. We knew that the College's nominations would hold weight with the Minister because of all the work the College had done over the years to get the Council established. The College's successful nominations were Mina Timu Timu, Sally Pairman, Sue Bree, Sharron Cole, Rea Daellenbach, Hope Tupara and Thelma Thompson. NZNO's successful nominee was Helenmary Walker. All the College's nominees were also supported by other organisations such as the Ministry of Women's Affairs, Parents Centre, La Leche League, Federation of Women's Health Councils, Homebirth Aotearoa, Otago Polytechnic and Auckland University of Technology.

In making its nominations the College looked for experienced midwives with a strong background in the political and professional history of midwifery. It considered that these were essential attributes for new Midwifery Council members that would be charged with the responsibility of establishing effective mechanisms to ensure the protection of women and babies in New Zealand. The College agreed with Judy Kilpatrick that *"the Council is not a training ground – that you don't put nurses (midwives) on who are learning"* (Wood & Papps, 2001, p.107).

The longstanding leadership roles of Sally Pairman and Sue Bree were recognised along with their previous regulatory experience on the Nursing Council. Mina Timu Timu's cultural guidance provided over many years to the midwifery profession together with Hope Tupara's experience on Nursing Council ensured that these Maori midwives were well placed to establish the Tikanga for Council. Equally the strong consumer advocacy and commitment of Sharron Cole and Rea Daellenbach were considered essential to the Council's women-centred functions. Thelma Thompson and Helenmary Walker contributed considerable experience in hospital based maternity services. Together all these women personified the strength of the woman-midwife partnership, contributed experience in education and all aspects of midwifery practice and gave the greatest hope of a strong and effective inaugural Midwifery Council. Once appointed council members elected Sally Pairman unanimously as the inaugural Chair and Sharron Cole was elected the inaugural Deputy Chair – a fitting example of partnership between women and midwives in action.

The wide-ranging strengths of this first Council proved invaluable as, other than the legislative requirements, it was faced with a completely blank slate within which to establish and implement its regulatory functions. The first meeting of the Council in February 2004 was funded by the Ministry of Health and hosted by the Registrations Board Secretariat. Sally recalls being welcomed by a Ministry official who gave Council a brief overview of its statutory functions and then left. With little guidance and no funding the tasks ahead certainly seemed daunting.

Fortunately Council members had a clear understanding of midwifery and the wider framework of the maternity and health services. It was able to draw on the work of the College and to some extend on the work done by the Nursing Council in collaboration with the College. For example the Council used the College's definition and scope of practice of a midwife statement and the Nursing Council's competencies for entry to the midwifery register as the basis for its first consultation document to define the Midwifery Scope of Practice. The original statements had largely passed the test of time and only required minor changes to reflect the current context and practice of midwives. These baseline documents were invaluable to getting the processes started.

From its beginning the Council was committed to ensuring that midwifery's partnership model was reflected in all its processes and policy development. Consultation in general was taken very seriously with the development of an extensive consultation list that included a large number of relevant consumer organisations as well as other professional organisations, and all midwifery and maternity provider groups. Feedback informed all major policy development and Council explained its decision making in an effort to ensure transparency.

An important principle for both the College and the Council was that the College's professional framework and the Council's regulatory framework were cohesive and complementary so that women and babies would benefit. The College's Midwifery Standards Review Process was a central mechanism in both frameworks.

Issues of funding

On the down side lack of funding has been a major issue for the Council and the midwifery profession. Although the profession knew it would have increased costs to support its own regulatory authority, preliminary discussions between NZCOM, the Nursing Council and the Minister of Health led the College to believe that some funding would be made available to the Midwifery Council. The College's expectation was that the Midwifery Council would receive the annual practising certificate fee for midwives for 2004-5 as well as a share of the Nursing Council's asset base. Statements in the Nursing Council newsletters of December 2003 and February 2004 reinforced this belief. In anticipation of transferring funds to the Midwifery Council the Nursing Council increased the midwifery APC fee for the 2004-2005 year from $50 to $100 GST inclusive (without discussion with any other party).

Despite the Nursing Council's expressed intention to support the new Midwifery Council it did not initiate any offer and it wasn't until the Midwifery Council wrote to request a

meeting in February 2004 that discussions began about any transfer of funding or other support. Negotiations began in early March and by early April there was agreement that the Midwifery Council would receive a percentage of the Nursing Council's asset based according to the percentage of midwives compared with nurses. In dispute was whether the Council would receive the full 2004/5 APC fee for midwives that had been collected by Nursing Council or its undisputed entitlement to 53% of the fee to cover the period from 18 September to 31 March 2005. This would amount to $87.50 or $46.37 per midwife once GST was removed.

This was all then put on hold when the Nursing Council raised the issue of the legality of transferring funds with their auditors. The Nursing Council then sought further advice from the Auditor General who agreed they had no power to transfer funds. However, the Auditor General pointed out that their view had no legal status and should not be treated as legal advice. The Midwifery Council sought advice from Health Minister Annette King who obtained a legal opinion from Health Legal. This opinion said

> *It is possible for the Nursing Council of New Zealand to transfer funds to the Midwifery Council from the current annual practising certificate income and from existing reserves* (Health Legal Advice to Annette King, 25 June 2004).

The same advice noted that if Audit New Zealand still had concerns then the Nursing or Midwifery Councils may need to contact Crown Law. Annette King reiterated that option in her letter to both Councils on 29 June, but it was not a directive.

However, the Nursing Council decided to seek a second option on the matter from Crown Law. The Crown Law opinion disagreed with the Health Legal opinion in relation to a transfer of a portion of the asset base but did agree that the Nursing Council must transfer the portion of the APC fee collected to cover the period after 18 September when the HPCAA came fully into force, as the Nursing Council had no authority to invoice midwives or collect fees from midwives beyond this date.

At the end of the day the Nursing Council collected over $270,000 from midwives in 2004 and transferred only 53% of this to the Midwifery Council; that is $46.37 for each midwife. Even then this fee was only received several months after the Midwifery Council commenced operating. As it had no operating funds the Midwifery Council was forced to obtain an overdraft and Council members did not claim payments for their work for many months.

The Ministry of Health had only one other solution to this unsatisfactory state of affairs. This was that the Midwifery Council seek a loan from the NZCOM. This suggestion was roundly rejected by the NZCOM National Committee as they believed there was an *"inherent conflict of interest in the organisation that represents the profession financially underwriting the regulatory body charged with monitoring that same profession"* (Personal correspondence from NZCOM to Annette King, 16 June, 2004).

The Midwifery Council and the College were deeply disappointed by this unexpected funding debacle and felt let down by both the Nursing Council and the Ministry of Health. We were willing in the beginning to accept that the Nursing Council believed itself to be

genuinely constrained by its legal opinion. However, the subsequent behaviour of the Nursing Council was very familiar to those midwives who had been members of the Nursing Council over many years. The Nursing Council tactics were once again classic passive-aggressive in nature as they stalled, denied, held back information, and even excluded the midwife members of the Nursing Council from most of the discussions on the funding of the new Midwifery Council. What was it they had to hide if they really wanted to help? We all realised that despite the protestations from Chairperson Annette Huntingdon and Chief Executive Marion Clark, they really had no intention of assisting the Midwifery Council when they turned down a further offer to resolve the situation. The Midwifery Council suggested that it could invoice the Nursing Council for the work it had undertaken during the transition period from December 2003 until the Midwifery Council became fully functioning in September 2004. The Nursing Council declined this solution on the grounds that because the Midwifery Council was established under the HPCAA the Nursing Council was not responsible for ensuring this work was done, even though they still had regulatory control over midwives and had collected their APC fees for this period.

The College had gone to some lengths to prevent situations like this developing. It tried to ensure that the establishment of the Midwifery Council and transfer from Nursing would go smoothly. The College was constantly reassured that all was in hand and yet neither the Nursing Council nor the Ministry had actually thought the implementation process through. As the legislation got closer the College became more and more anxious about the lack of clarity and less and less convinced by assurances from the Ministry and the Nursing Council. It initiated investigation into some of the structures available to a new Council. With the help of Marion McLaughlin, midwife and ex Registrar of the Nursing Council, the College found and contacted Registrations Board Secretariat (RBS) that provided secretariat services for a number of the other smaller allied health professions. Sue Bree, Sandy Grey, Mina Timu Timu, Norma Campbell and Karen met with RBS on two occasions to discuss what services RBS could provide to the new Council once it was appointed. As a result RBS offered to host the first meeting of the new Midwifery Council and present a proposal in relation to its services. At least the College now had a plan, if, as it suspected, it turned out that no-one else did.

Much later in the process and some time after the Midwifery Council had taken up the RBS secretariat contract the Nursing Council disingenuously offered the use of its CEO, its rooms and its services.

Whilst the College had some anxieties about the likelihood of a smooth transition, none of us were prepared for the reality of starting midwifery regulation with no money, no information, no workforce data, no register or registrar and no support. We should not have been surprised. Even when information and registers were handed over there were gaps and inaccuracies that took many months to sort out. The final indignity was to receive an emailed invitation one week prior to a cocktail party hosted by the Nursing Council in order to celebrate the establishment of the Midwifery Council. Midwifery was outraged and most midwifery groups declined to attend. The College suggested that the money being spent on the cocktail party could be forward to the cash-strapped Midwifery Council.

Conclusion

It was a long road to the Midwifery Council. In fact it was 100 years from the first Midwives Act in 1904 to the HPCAA in 2003 and the fully operational Midwifery Council in 2004. The first two years of operation have been like the early years of the College and have relied on the generosity and commitment of Council members and its two staff members (Registrar Susan Yorke and Deputy Registrar Nick Bennie) to accomplish an extraordinary workload and a smooth transition for midwives. Midwives have never been so consulted over midwifery regulatory matters in the history of New Zealand midwifery. While the majority of midwives welcome this there has been some resistance to self-regulation and of course to its costs. However, this is all part of the change process and we are confident that midwives, women and babies will look back on this era and be pleased with the profession's progress.

REFERENCES

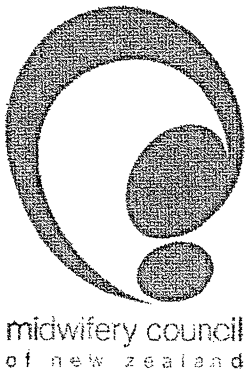
Department of Health. (1990). *Draft Policy Paper Reviewing the Nurses Act 1977.* Department of Health)

Department of Health. (1997). *Reform of Health Sector Occupational Regulation Statutes.* Department of Health.

Ministry of Health. (2004). *Discussion Document on Restricted Activities under the HPCA Act 2003*, August. Wellington: Author.

Health Practitioners Competence Assurance Act, 2003. [NZ].

Wood, P.J. & Papps, E. (2001). *Safety to practise. Reflections of the Chairpersons of the Nursing Council of New Zealand 1971-2001.* Wellington: Nursing Council of New Zealand.



Recertification Programme: competence-based practising certificates for midwives

Policy Document

Pursuant to Section 41 Health Practitioners Competence Assurance Act 2003

Approved by Council on 11 November 2004

Updated 6 March 2005

Review date: 11 November 2005

Overview

The Health Practitioners Competence Assurance Act (2003) requires the Midwifery Council, among other things, to:

- Set standards of clinical competence, cultural competence, and ethical conduct, and
- Review and maintain the competence of midwives

A midwife may not be issued with an annual practising certificate unless the Midwifery Council is satisfied that the midwife meets the required standard of competence.

This document outlines the Midwifery Council's Recertification Programme policy. Participation in this Recertification Programme will enable registered midwives to demonstrate that they are competent to practise within the Midwifery Scope of Practice and thereby satisfy the Midwifery Council that they meet the standards to be issued with an annual practising certificate.

This programme will be implemented from 2005. The Midwifery Council will review the programme by November 2005 to ensure that any issues with the programme and its implementation are identified and addressed, and further, to ensure that the Recertification Programme is meeting Council's objectives.

Further copies of this document may be downloaded from the Midwifery Council website: www.midwiferycouncil.org.nz

Note:

In this document the feminine pronoun includes the masculine.

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1 PART ONE: OVERVIEW

1.1 Introduction

The Health Practitioners Competence Assurance Act (HPCAA) 2003 requires the Midwifery Council to be satisfied that any midwife applying for an annual practising certificate is competent to practise within the Midwifery Scope of Practice.

Under Section 41 of the HPCAA the Midwifery Council has resolved that all registered midwives must participate in its Recertification Programme in order to meet the competence requirements necessary for an annual practising certificate to be issued.

This policy sets out the required standard of competence expected of midwives practising within the Midwifery Scope of Practice and describes the Recertification Programme that midwives must undertake in order to demonstrate that they have maintained competence to practise.

1.2 Standard of competence expected of registered midwives

1.2.1 *Midwifery Scope of Practice*

The Midwifery Scope of Practice provides a broad statement of the boundaries of what a New Zealand midwife can do on her own professional responsibility. As required under the HPCAA (2003) the Midwifery Council has defined the scope of practice for registered midwives and published this in the Gazette.

The Midwifery Scope of Practice[1] is as follows:

> *The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn*[2].
>
> *The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.*
>
> *Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.*
>
> *The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides* (Midwifery Council, 2004).

1.2.2 Competencies for Registration as a Midwife

Under the HPCAA (2003) the Midwifery Council is also required to determine the level of competence required for a midwife to work within the Midwifery Scope of Practice. This level of competence is defined in the Midwifery Council 'Competencies for Entry to the Register of Midwives'[3].

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[1] The Midwifery Scope of Practice was defined after a period of consultation with midwives in May 2004. The NZCOM (2002) definition of a midwife was used as a basis for this consultation. That definition, in turn, was adapted from the WHO definition of a midwife. As a result of the consultation the Midwifery Council made small changes to the NZCOM definition and this was the adopted as the Midwifery Scope of Practice in July 2004.

[2] In relation to a preterm baby the Midwifery Council defines the six-week postpartum period as commencing from the expected date of birth rather than from the actual date of birth. That is, Council recognises that the postpartum midwifery role for preterm babies may extend beyond six calendar weeks.

[3] In May 2004 the Midwifery Council consulted on the Nursing Council of New Zealand's (1996) 'Competencies for Entry the Register of Midwives'. These four competencies were developed by the Nursing Council in consultation with the midwifery profession and were used to determine the level of competence required for graduates from New Zealand midwifery programmes since 1996. The Midwifery

The Competencies for Entry to the Register of Midwives provide detail of the skills, knowledge and attitudes expected of a midwife to work within the Midwifery Scope of Practice. Where the Midwifery Scope of Practice provides the broad boundaries of midwifery practice, the competencies provide the detail of how a registered midwife is expected to practise and what she is expected to be capable of doing. By defining the minimum competence standards for registration as a midwife in New Zealand the Midwifery Council has established the minimum standard that all midwives are expected to maintain in their ongoing midwifery practice.

The Competencies for Entry to the Register of Midwives are as follows:

Competency One

"The midwife works in partnership with the woman throughout the maternity experience."

Explanation
The word midwife has an inherent meaning of being "with woman". The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early parenthood. The midwifery relationship enhances the health and well-being of the woman, the baby and their family/whanau. The onus is on the midwife to create a functional partnership. The balance of 'power' within the partnership fluctuates but it is always understood that the woman has control over her own experience.

Competency Two

"The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care."

Explanation
The competent midwife integrates knowledge and understanding, personal, professional and clinical skills within a legal and ethical framework. The actions of the midwife are directed towards a safe and satisfying outcome. The midwife utilises midwifery skills that facilitate the physiological processes of childbirth and balances these with the judicious use of intervention when appropriate.

Council made minor modifications to the four competencies and formally adopted these as entry-level standards in July 2004.

Competency Three

"The midwife promotes practices that enhance the health of the woman and her family/whanau and which encourage their participation in her health care."

Explanation Midwifery is a primary health service in that it recognises childbirth as significant and normal life event. The midwife is therefore responsible for supporting this process through health promotion, education and information sharing, across all settings.

Competency Four

"The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care."

Explanation As a member of the midwifery profession the midwife has responsibilities to the profession. The midwife must have the skills to recognise when midwifery practice is safe and satisfactory to the woman and her family/whanau.

Please note that each of these competencies has accompanying criteria for measurement. The full Competencies for Entry to the Register of Midwives, with the associated criteria, can be downloaded from the Midwifery Council website: www.midwiferycouncil.org.nz.

1.3 Maintaining competence to practise

The Midwifery Council defines maintaining competence to practise for registered midwives as, *"the ongoing capacity to integrate knowledge, skills, understanding, attitudes and values within the professional framework of the Midwifery Scope of Practice"*.

Through participation in the Midwifery Council's Recertification Programme midwives demonstrate their continuing competence to practise and, therefore, their competence to be issued with an annual practising certificate. Participation in the Recertification Programme requires a commitment to lifelong learning and professional development by midwives.

1.4 Background to the development of the Recertification Programme

In June 1999 the Nursing Council of New Zealand (NCNZ) produced guidelines for competence-based practising certificates for midwives (NCNZ, 1999). These guidelines were developed in collaboration with the New Zealand College of Midwives (NZCOM) and the New Zealand Nurses Organisation (NZNO). The guidelines were developed in anticipation of changes in regulation that would require midwives to demonstrate their ongoing competence in order to continue to practise.

The Health Practitioners Competence Assurance Act 2003 has now established this regulatory framework and from April 2005 all health professionals are required to demonstrate their continuing competence to practise at the minimum level required for entry to the profession. It is the responsibility of the Midwifery Council of New Zealand to set the competence standards and to establish a process by which to determine the ongoing competence of midwives.

The Midwifery Council considered the guidelines developed by the Nursing Council when it developed its Recertification Programme proposal. The Midwifery Council consulted widely on its proposed Recertification Programme in August and September 2004. It made changes in response to feedback and finalised its Recertification Programme as policy on 11 November 2004. This policy was updated in March 2005. Midwives were notified of the requirements by newsletter and through the website.

Implementation of the Recertification Programme began in 2005 and in order to obtain an APC in April 2006 all midwives will need to sign a declaration that they are participating in the Recertification Programme. The Midwifery Council will commence auditing individual midwife participation in 2006. All midwives who obtained a Midwifery APC by 1 April 2005 will have completed their first cycle of the Recertification Programme by 31 March 2008.

1.5 Overview of the Recertification Programme

The Midwifery Council Recertification Programme focuses on the professional development needs of each individual midwife within a national professional framework. This professional framework is supportive and educative, not punitive. It aims to assist each individual midwife to examine her professional role in relation to the Midwifery Scope of Practice and competencies for registration as a midwife, to identify individual strengths and weaknesses and to develop an individual professional development plan that will assist the midwife to continually develop her practice. Through this process nationally, the midwifery profession will collectively engage in a process of self-reflection and professional development that will improve standards of midwifery care and contribute to ongoing quality improvement in the midwifery workforce.

The Midwifery Council recognises that District Health Boards, as employers, and the midwifery profession, through the New Zealand College of Midwives, share the Midwifery Council's interest in ensuring public safety by requiring midwives to work to acceptable standards and engage in ongoing professional development.

The Midwifery Council Recertification Programme focuses on maintaining competence for all midwives, wherever they work. Participation in the programme by employed midwives will help meet the DHBs' needs by ensuring that midwives they employ maintain competence to practise in order to obtain an annual practising certificate. Likewise, participation in the Recertification Programme will assist midwives practising as Lead Maternity Carers under Section 88 to meet their obligations under that legislation to participate in a Professional Review Process. Participation in the Recertification Programme assists midwives to identify and develop their ongoing professional development plan and DHBs can assist their midwife-employees through providing support for their professional development needs.

The provision of a single national Recertification Programme for all midwives means that all midwives are required to collect the same information, in the same way, to provide evidence of their ongoing competence and to establish their individual professional

development plans. The Midwifery Council's Recertification Programme enables national consistency and contributes to improving the standards of midwifery practice across all midwives in all practice settings. New Zealand midwives, wherever they work, have access to a seamless process for professional development.

2 PART TWO: RECERTIFICATION PROGRAMME

In designing its Recertification Programme the Midwifery Council has taken a holistic approach to midwifery practice and has provided a professional framework within which each midwife can examine her practice.

2.1 Components of the Recertification Programme

In summary the components of the Recertification Programme are as follows:

a) Declare competence to practise within the Midwifery Scope of Practice (annually on application for APC) (see 2.1.1)

b) Demonstrate competence at entry to register level within all aspects of the Scope of Practice over each three-year period (from date of first APC with Midwifery Council) by:
   - Practice across the Scope over a three-year period (see 2.1.2 and Appendix Two)
   - Maintenance of a professional portfolio containing information and evidence about practice, and education and professional activities over each three-year period (from date of first APC with Midwifery Council and subsequent APC applications) (see 2.1.3), and
   - Participation in New Zealand College of Midwives Midwifery Standards Review Process (MSR) at least once in each three-year period (from date of first APC with Midwifery Council) (see 2.1.4).

c) Midwifery Council audit of:
   - Individual midwives' compliance in the Recertification Programme (see 4.1), and
   - NZCOM's management of the Midwifery Standards Review component of this programme (see 4.2).

See Appendix One for summary of Recertification Programme.

2.1.1 Declaration

Each year, when applying for an annual practising certificate, each midwife is required to make a declaration that she is competent to practise within the Midwifery Scope of Practice. The midwife will be able to make this declaration on the basis that,

- She is currently practising midwifery and has ensured that over the past three years she has demonstrated competence in all aspects of the Midwifery Scope of Practice, and
- She is participating in the Recertification Programme

2.1.2 Practises within the Midwifery Scope of Practice

Each midwife is required to make an annual declaration that she is competent to practise within the Midwifery Scope of Practice. This means that each midwife will have to make a professional judgment about her own competence.

The Midwifery Council expects that over each three-year period (from date of first APC with Midwifery Council) each midwife will make sure that she can demonstrate competence across all aspects of the Midwifery Scope of Practice, ie. antenatal, labour, birth, postnatal period (if this is not already her usual scope) and that she has undertaken any necessary updating to ensure that she is still competent to meet **all** criteria listed under each of the four Competencies for Entry to the Register of Midwives. The midwife must provide evidence of this practice experience and competence within her portfolio. This will be discussed at the review process. The information must also be made available to the Midwifery Council if the midwife is audited.

The length of time and type of practice experience required by midwives to demonstrate that they are competent to work in the full Midwifery Scope of Practice will vary from midwife to midwife and is a professional judgment of each individual midwife. It is important to recognise that the Competencies for Entry to the Midwifery Register are entry level only and that the competencies do not expect expertise in more specialised

aspects of midwifery practice such as caring for women with complex needs in tertiary facilities or working with women in isolated rural areas. They do expect a midwife to be capable of providing care to a woman across the childbirth experience, on her own responsibility, and in partnership with the woman.

See Appendix Two for examples of how this might be achieved.

2.1.3 Portfolio

The midwife's portfolio or personal professional profile is the central collection point for information about her practice and her ongoing education and professional development. The information contained in this portfolio provides evidence of the midwife's continuing competence to practise.

All midwives (including those who work part-time) who need to hold an annual practising certificate will be expected to provide evidence of their activities under each of the identified sections in the portfolio over each three-year period. This includes certain compulsory education, 40 points of elective education and 60 points of professional activity.

The portfolio will contain the following elements:

a) Evidence of continuing education[4]:

- Completes **compulsory** approved[5] ongoing education from approved[6] education providers over three years:

[4] Note that this equates to a minimum of approximately 7 - 8 days of continuing education over three years.
[5] Education programmes will need to be approved by the Midwifery Council and have points allocated before they can be used for evidence of continuing education in the Recertification Programme. See Appendix Four. The process for approval involves sending the Council a copy of the course outline, hours, delivery mode, assessment procedures and any other relevant information. The Council will assess this information against its criteria for approval and allocation of points. There is no cost for education providers in having programmes approved or points allocated. Council is interested in ensuring that midwives have access to a variety of continuing education opportunities and is particularly keen to see the development of distance or on-line courses that will improve access for all midwives
[6] Only approved providers can provide the compulsory education courses. NZCOM, DHBs, Polytechnic Schools of Midwifery, and University Schools of Midwifery are automatically approved as education providers for compulsory education in the Recertification Programme. Other providers may apply for approval.

- 40 points of **elective** approved ongoing education over three years

b) **Evidence of professional development activities.**
   - 60 points of professional development activities over three years

Compulsory education will consist of the following:

a) Technical Skills Workshops.

   These are integrated, women centred, two-day courses that will be provided by approved education providers. The Midwifery Council will set the criteria, content and process of these courses. The focus is to enable midwives to update certain basic technical skills on a regular basis. Midwives must undertake at least one technical skills workshop once in each three-year period (from the date of first APC with the Midwifery Council and subsequent APC applications). Approved education providers will be required to submit copies of their courses to the Midwifery Council for approval before they are offered and before providers can state that the Council has approved their course. See Appendix Three for details of the Technical Skills Workshops to be provided from 2005 – 2008 and the criteria for approval.

b) Neonatal resuscitation.

   Midwives must update these skills every year (as per professional guidelines). These updates are offered by DHBs and other providers and last two hours on average. DHBs and other providers (see footnote 5) are automatically approved to provide these courses under the Recertification Programme. The courses do not need to be submitted to the Council for approval but midwives will need to provide evidence of attendance in their portfolios.

c) Adult CPR.

Midwives must update these skills every year. These updates are offered by DHBs and other providers and last two hours on average. DHBs and other providers (see footnote 5) are automatically approved to provide these courses under the Recertification Programme. The courses do not need to be submitted to the Council for approval but midwives will need to provide evidence of attendance in their portfolios.

d) Breastfeeding workshops.

Midwives must attend a breastfeeding workshop or some sort of breastfeeding update as appropriate to their needs at least once every three years (from date of first APC with Midwifery Council and from subsequent APC applications). DHBs and other providers offer these updates and they last half-a-day to a day. DHBs and other providers (see footnote 5) are automatically approved to provide these courses under the Recertification Programme. Approved education providers will be required to submit details of their courses to the Midwifery Council for approval before they are offered and before providers can state that the Council has approved their course (see Appendix Four). Breastfeeding courses must be in line with the WHO 'Ten Steps to Successful Breastfeeding' and the Baby Friendly Hospital Initiative (New Zealand Breastfeeding Authority, 1999).

Please note that midwives, who teach the compulsory courses, including Technical Skills Workshops, will fulfil the compulsory education requirements for the course they teach. Council expects these midwives to maintain their level of knowledge in these teaching areas through continuing education and practice.

See Appendix Four for more detail of portfolio requirements and allocation of points.

2.1.4 NZCOM Midwifery Standards Review Process

NZCOM has had an established Midwifery Standards Review process since the early 1990s and over this time it has developed and refined the process to the quality,

nationally consistent process it is today. The Midwifery Standards Review process is a professional process that focuses on professional standards. As such it is distinct from employer processes or peer review processes run by groups of midwives. Its only interest is in the improvement of midwifery standards and it achieves this through education and support that enables each individual midwife to examine her practice, identify her strengths and weaknesses, and develop her professional development plan to help her achieve her goals.

As a national process provided by the profession, the Midwifery Standards Review process provides each midwife with an individual opportunity to examine her practice with colleagues and consumer representatives. As such it provides a unique mechanism for the Midwifery Council to include as an essential component of its Recertification Programme.

Each midwife is required to undergo an individual review at least once in each three-year period (from the date of first APC with the Midwifery Council). The midwife must bring her portfolio to the review and this will be discussed with the Review Panel. The midwife must provide material to the Midwifery Standards Review Panel prior to the review as required. This includes:

a) Evidence of consumer/client/colleague feedback and evaluation (individual and/or facility)
b) Evidence of clinical outcomes (annual statistical data for midwife's practice or facility for core midwives)
c) Self-assessment against the Competencies for Entry to the Register of Midwives and NZCOM Standards for Practice
d) Evidence of reflection on practice.

On completion of each review the Midwifery Standards Review Panel will assist the midwife to establish her personal Professional Development Plan for the coming years. This may include identifying areas of personal development as well as professional development or education. The midwife receives a certificate as evidence of her

participation in the review and the Midwifery Council will request to see this if the midwife is subject to any audit of her participation in the Recertification Programme or at any other time required by the Midwifery Council.

All midwives are required to undergo review every three years. However, some midwives will be required to be reviewed more frequently as follows:

- New graduate midwives, and midwives who have completed a Return to Practice Programme, will be reviewed at the end of their first year in practice, at the end of their third year and then three-yearly
- Midwives from overseas who are newly registered with the Midwifery Council of New Zealand, or returning to New Zealand after a period away and renewing their Annual Practising Certificate, will be reviewed at the end of their first year in practice, at the end of their third year and then three-yearly
- Midwives practising under Section 88 (Ministry of Health, 2002) must be reviewed annually in order to meet their obligations under Section 88 to participate in a Professional Review Process. Annual participation in NZCOM's MSR process is the Professional Review Process approved by the Midwifery Council of New Zealand. At the discretion of the Midwifery Standards Review Panel the annual review of midwives practising under Section 88 may be extended to two-yearly for those midwives who demonstrate consistently high standards of reflective practice.
- Any midwife, about whose practice a Midwifery Standards Review Panel has concerns, can be required to be reviewed again the following year, and annually until the Review Panel is satisfied that the midwife can be reviewed three-yearly.

Under Section 34 of the Health Practitioners Competence Assurance Act 2003, if any individual midwife has serious concerns about another midwife's competency such that she believes the midwife may pose a risk of harm to the public by practising below the required standard of competence, the midwife may notify the Midwifery Council in writing of these concerns and the reasons for them. In the same way, any Midwifery

Standards Review Panel that has serious concerns about a midwife's standard of competence may notify the Midwifery Council in writing of these concerns.

3 PART THREE: PARTICIPANTS IN THE RECERTIFICATION PROGRAMME

All midwives who wish to practise midwifery in New Zealand (as defined by the Midwifery Scope of Practice) must have an annual practising certificate[7]. All midwives who require an annual practising certificate for their employment or work as a midwife must participate in the Midwifery Council's Recertification Programme.

Midwives who have not practised midwifery in the previous three years will be required to undertake a Return to Practice Programme before they can obtain an annual practising certificate. This is a requirement of the HPCAA. The Midwifery Council's Return to Practice policy is outlined in a separate document and can be downloaded from the Midwifery Council website.

3.1 Midwifery Educators

All midwifery educators who teach clinical practice must have an annual practising certificate. In order to demonstrate their competence to practise within the Midwifery Scope of Practice midwifery educators who teach clinical papers will need to maintain some midwifery practice. Suggestions of ways to maintain practice across the Midwifery Scope of Practice are provided in Appendix Two.

3.2 Midwives in non-clinical positions

Midwives who are in non-clinical positions, but who are actively involved in midwifery, such as some heads of schools, midwifery managers, midwifery advisors or researchers, will need to consider whether they require an annual practising certificate for their work. If they do then they will be required to participate in the Recertification Programme in

[7] Guidance is provided for midwives working outside of the Midwifery Scope of Practice in the Midwifery Council's document "Information for Midwives Working Outside of the Midwifery Scope of Practice" (October 2004). Further updated information is provided in the Council's document "The Midwifery Scope of Practice: further interpretation" (March 2005). These documents can be downloaded from the Midwifery Council website.

the same way as all other midwives. Suggestions as to how these midwives can maintain practice are outlined in Appendix Two.

3.3 Midwives in part-time practice

Part-time midwives will need to participate in the Recertification Programme in the same way as all other midwives.

3.4 Midwives working outside of the Midwifery Scope of Practice

Midwives working outside of the Midwifery Scope of Practice can choose whether or not they maintain their Midwifery Practising Certificate (see footnote 6). Midwives remain on the Register of Midwives for life unless they are removed through a disciplinary process. However, midwives who do not maintain their practising certificate or who do not practice across the Midwifery Scope of Practice for three or more years will be required to complete an approved Return to Practice programme before they can be issued with a Midwifery Annual Practising Certificate.

3.5 Direct entry midwives

Midwives who registered through a direct entry midwifery programme, and who have not subsequently gained registration as a nurse, must maintain their midwifery practising certificate in order to practise in any area. This means that even though a direct entry midwife may be employed in an area that is outside of the Midwifery Scope of Practice, such as a Family Planning Clinic or gynaecology ward, she must participate in the Recertification Programme in order to maintain her annual practising certificate (see footnote 6). In these cases midwives must find ways to maintain their competence across the full scope of midwifery practice even if this is not part of their daily work. Employers will need to facilitate this for these employees. Suggestions as to how this experience can be obtained are provided in Appendix Two.

3.6 New Zealand midwives working overseas

New Zealand midwives working as midwives overseas are not required to maintain their New Zealand Midwifery Practising Certificate. As long as these midwives have practised midwifery within three years prior to their return home they will be eligible for an Annual Practising Certificate. These midwives will then be required to participate in the Recertification Programme and will be required to undertake Midwifery Standards Review at the end of their first year in practice, at the end of their third year and then three-yearly (unless working under Section 88 as an LMC, in which case they must be reviewed annually). Midwives are encouraged to keep documentation of any continuing education they undertake whilst overseas and to include this in their portfolios once they return home.

Midwives who have not practised midwifery in the three years preceding their return to New Zealand will be required to undertake a Return to Practice programme in order to be issued with an Annual Practising Certificate. These midwives will then be required to participate in the Recertification Programme and will be required to undertake Midwifery Standards Review at the end of their first year in practice, at the end of their third year and then three-yearly.

Midwives who wish to maintain their APC whilst overseas will need to develop a plan with the Midwifery Council as to how they will fulfil the recertification requirements whilst overseas. Council acknowledges that these midwives will not have access to Midwifery Standards Review while overseas but expects these midwives to undergo review at the end of their first year of practice back in New Zealand, and then three yearly (depending on where they choose to work).

4 PART FOUR: QUALITY ASSURANCE AND AUDIT

The following processes for audit and quality assurance will be implemented to ensure that the Midwifery Council Recertification Programme is working effectively and efficiently.

4.1 Evidence of participation in the Recertification Programme

Each time a midwife applies for an Annual Practising Certificate she will be required to provide the Council with evidence of her participation in the Recertification Programme over the previous three years. This evidence will take the form of a written summary of her practice across the scope, her completion of the compulsory education courses, her achievement of 40 points of approved elective education and her achievement of 60 points of professional activity. In time Council hopes to develop an on-line process through which midwives can record their recertification activities on the Midwifery Council website.

4.2 Audit of individual midwives

Each year (from April 2006) a percentage of the midwives applying for annual practising certificates will be audited by the Midwifery Council to ensure that they can provide evidence of their ongoing competence to practise and their participation in the Recertification Programme. The actual percentage figure will be set in April 2005 when Council has more accurate knowledge of how many midwives hold a Midwifery APC.

Midwives will be notified of the audit and asked to send their portfolios containing evidence of compulsory and elective education and of professional activities. Midwives must also provide evidence of participation in the NZCOM Midwifery Standards Review process, if completed, or provide the dates for which their review is booked. Any Professional Development Plan arising from Midwifery Standards Review must also be provided.

Midwives who cannot provide satisfactory evidence of continuing competence to practise or participation in the Recertification Programme, may be subject to any one or more of the following:

- Undertake Competence Review
- Undertake Competence Programme
- Conditions on Scope of Practice
- Restrictions on Annual Practising Certificate
- Suspension of Annual Practising Certificate

4.3 Audit of NZCOM's provision of MSR as a component of the Midwifery Council's Recertification Programme

In utilising the New Zealand College of Midwives Midwifery Standards Review process as an essential component in its Recertification Programme, the Midwifery Council recognises and endorses the following quality aspects of NZCOM's Midwifery Standards Review processes:

- National standards and national consistency
- Transparent processes for selection of reviewers (midwives and consumers)
- National training programmes for all reviewers
- Profession-based rather than employer or industrial

In utilising NZCOM's Midwifery Standards Review process the Midwifery Council has sought assurance from NZCOM that this review process will be accessible, affordable and appropriate for all midwives, employed and self-employed. See Appendix Five for information about fees for MSR.

The Midwifery Council will establish a formal audit system to monitor NZCOM in its provision of the Midwifery Standards Review component of the Recertification Programme. The audit will include the following:

- Quality processes
- Accessibility
- Cost
- Participant satisfaction
- Reporting
- Portfolios and levels of evidence accepted by Midwifery Standards Reviewers

Midwives may be asked to contribute to this audit process. Auditing of NZCOM's provision of MSR will commence in 2005.

5 PART FIVE: TIMEFRAME FOR IMPLEMENTATION

Midwives are expected to continually maintain their portfolios and keep them up to date, making sure that they meet all requirements each year. The Midwifery Council recognises that midwives, particularly those who have not undertaken a Midwifery Standards Review previously, will need time to begin their portfolios and prepare for review. NZCOM will also need time to bring its Midwifery Standards Review processes up to capacity so that all midwives can be reviewed at least every three years, and some more frequently.

Therefore the Recertification Programme will be implemented from 2005 to 2008. Midwives were notified of the Recertification Programme requirements before the end of 2004 via the Midwifery Council website and Midwifery Council Newsletter. From that date all midwives should have begun to prepare their portfolios and begun to participate in the Recertification Programme requirements as outlined in Appendix Two.

Midwives will begin to participate in MSR through NZCOM from 2005 and all midwives must have undertaken at least one review by 31 March 2008, unless they are a category of midwife who needs to undertake MSR more frequently. Midwives will need to book their reviews through the MSR National Coordinator. Those midwives requiring triennial review, and who were reviewed in 2004, can wait until 2007 before being reviewed.

New graduates, midwives returning to practice and those midwives from overseas who are newly registered in New Zealand or renewing their APC after an absence from New Zealand, must be reviewed after their first year in practice and after their third year before commencing a three-year cycle of review. Midwives working under Section 88 must be reviewed annually. Some other midwives may be reviewed more frequently at the request of a Midwifery Standards Review Panel.

The audit process for NZCOM will commence in 2005 and for individual midwives from April 2006.

6 PART SIX: INFORMATION OBTAINED FROM NZCOM

NZCOM will not inform the Midwifery Council of the details of an individual midwife's review, other than the fact that the midwife has undertaken review. Information gathered about a midwife remains confidential to the Midwifery Standards Review Panel and the midwife. The Review Panel keeps no written documentation and the portfolio remains the property of the midwife. The Review Panel provides each midwife with a Review Certificate as verification that she has undertaken the review. The Review Panel also assists each midwife to establish and develop a Professional Development Plan. The midwife may choose to share this plan with her employer (if appropriate) and may be asked to provide this plan to the Midwifery Council for audit, for part of a Competence Review or at any other time at Council's request.

On rare occasions NZCOM Midwifery Standards Reviewers may become concerned about the competence of a midwife. This may be the result of ongoing resistance by a midwife to implementing the Professional Development Plan recommended by the Review Panel or ongoing resistance to making changes to her practice to meet competence standards. On these rare occasions NZCOM may inform the Midwifery Council in writing of its concerns as per section 43 of the HPCAA.

From time to time the Midwifery Council may request NZCOM to follow up on particular aspects of a midwife's practice at her next Midwifery Standards Review. These requests would usually be made as a result of a Competence Review or Professional Conduct Committee process.

NZCOM will provide the Midwifery Council with any non-identifiable information it gathers through the Recertification Programme in relation to trends in practice, professional development priorities, barriers to participation, and resistance to participation. The Midwifery Council may use this information to inform the

requirements for ongoing education or to make other modifications to its Recertification Programme.

7 PART SEVEN: SUMMARY

The Midwifery Council's Recertification Programme must be undertaken by all midwives in order to demonstrate ongoing competence to obtain an annual practising certificate. The programme has five essential components: annual declaration of competence; evidence of competence to practise at entry level; maintenance of a professional portfolio of information about practice, education, and professional activities; participation in the NZCOM Midwifery Standards Review process; and audit.

This Recertification Programme is similar to the guidelines for competence based practising certificates developed by the Nursing Council in 1999 but never implemented. There are four main differences.

1. The Midwifery Council has identified certain elements that must be provided within each midwife's portfolio, including set requirements for continuing education and professional activities;
2. The Midwifery Council requires all midwives to participate in the New Zealand College of Midwives' Midwifery Standards Review Process at least once every three years;
3. The Midwifery Council will audit a percentage of all midwives with annual practising certificates each year to ensure that they are participating in the Recertification Programme. This will include audit of individual midwives' portfolios, Review Certificates and Professional Development Plans.
4. The Midwifery Council will audit NZCOM's management of the Midwifery Standards Review component of the Recertification Programme and its quality assurance processes.

The Midwifery Council's Recertification Programme provides a single national framework for professional development. Council anticipates that employers such as District Health Boards (DHBs) will be able to modify existing professional development programmes or clinical career pathways, and those currently in development, to integrate

with the Council's Recertification Programme. Council recognises the benefit to midwives of being able to use the information collected in their portfolios, evidence of having undertaken a review and information contained within Professional Development Plans to also meet employer requirements.

8 PART EIGHT: APPENDICES

8.1 Appendix One: Summary of Midwifery Council of New Zealand Recertification Programme

Component	Detail	Timeframe
Declaration	Signed declaration of competence to practise within the Midwifery Scope of Practice.	Annual
Practise within the Scope of Practice	Demonstrates competence across all areas of Scope by case loading, by rotation through areas or by some other mechanism.	Over three years (See Appendix Two for examples of practice requirements)
Maintains portfolio	As below:	Continuous
Completes compulsory education	• Technical Skills workshop • Neonatal resuscitation update • CPR update • Breastfeeding workshop	Once in three years (see Appendix Three) Annually Annually Once in three years
Completes elective continuing education from approved courses to minimum of 40 points	Eg: • Postgraduate midwifery programmes • NZCOM Smoke Change workshop • NZCOM Family Violence Intervention workshop • DHB updates • Approved short courses from Education Providers and others (see Appendix Four) • 10 point allocation to 'non-approved' courses such as Treaty of Waitangi or computer skills	Over three years (See Appendix Four)

Undertakes professional activities to a minimum of 60 points	Eg: Student supervision; mentoring; member of MSRC; perinatal mortality meetings; conference attendance; clinical audit; policy guideline development; peer teaching sessions; case presentation; conference presentation; publication	Over three years (See Appendix Four for points)
Undertakes NZCOM Midwifery Standards Review	• Presents and discusses portfolio • Discusses outcome data • Discusses Consumer/client/colleague feedback • Self-assesses against the Competencies for Entry to the Register of Midwives and NZCOM Standards for Practice • Establishes Personal Development Plan for next three years	At least once every three years except; • New graduates and midwives returning to practice, at end of first year of practice and at end of third • Overseas midwives and NZ midwives returning from overseas, at end of first year of practice and at end of third • Midwives working under Section 88 annually • Any midwife requested to return for review by MSR Review Panel
Audit of midwives	Provide portfolio and any other information to Midwifery Council on request	Midwifery Council will audit percentage of all midwives with APCs each year to ensure participation in Recertification Programme
Audit of NZCOM provision of Midwifery Standards Review component of Recertification Programme		Regular audit. From time to time the Midwifery Council may approach individual midwives for feedback on NZCOM's MSR process as part of this audit component.

8.2 Appendix Two: Information about practice requirements

As a guide only, the Midwifery Council provides the following examples of how midwives might demonstrate their competence in all aspects of the Midwifery Scope of Practice. Council recognises that there may be other innovative ways that midwives will be able to demonstrate their competence across the Scope and encourages midwives to inform it of these innovations.

A). For midwives working in only one aspect of the scope such as postnatal or labour ward:

- Approach the DHB or LMC midwife for assistance to work in supernumerary capacity across other aspects of the Midwifery Scope of Practice.
- Rotate through other areas of the facility (antenatal, labour ward, postnatal) or into a primary maternity unit if usually work in a secondary/tertiary unit, or
- Work alongside an LMC midwife colleague in the provision of care to one or more women throughout the childbirth process.

  And:
- Work with a mentor to help identify any professional development needs and to provide support, and
- Complete any necessary skills updates, or
- Consider Return to Practice programme if have only worked in one area for many years.

B). For midwifery educators teaching midwifery practice subjects:

- Consider locum relief work for midwife LMCs
- Consider locum relief in primary maternity units

- Negotiate with DHBs to work in supernumerary positions across all areas of the maternity facility
- Work as an LMC for a certain number of women within a three-year period

C). For midwifery educators, managers, advisors, researchers and others in non-clinical positions and who are not involved in any 'hands on' midwifery practice:

- Consider if you need an annual practising certificate for your work (you do not lose your midwifery registration unless through a disciplinary process).
- Undertake a Return to Practice programme if you have been out of any clinical practice for more than three years or have not held an annual practising certificate for more than three years.
- Consider the solutions identified under (A) above.

D). For midwives working outside of the Midwifery Scope of Practice

- Consider if you need an annual practising certificate for your work (you do not lose your midwifery registration unless through a disciplinary process). (See footnote 6, p.20).
- Undertake a Return to Practice programme if you have been out of any midwifery clinical practice for more than three years or have not held a Midwifery APC for more than three years.
- Consider the solutions identified under (A) above.

8.2 Appendix Three: Technical Skills Workshop: Content 2005 – 2008 and approval criteria and process

For each three-year period the Midwifery Council will set the content areas for the compulsory Technical Skills Workshops. This content will reflect identified areas of practice that need strengthening or revision by the whole profession. Midwives are encouraged to send their ideas of areas for focus to the Council for consideration for inclusion in future workshops.

Technical Skills workshops are two-day workshops and can be provided by any Approved Education Provider (see footnote 4). Approved Education Providers must send course documentation (including objectives, content, process, assessments, resources, evaluation processes) to Council for approval before they can advertise it as an approved programme (see below). Ideally workshops will be provided collaboratively by one or more approved provider (eg, DHB and School of Midwifery or NZCOM, School of Midwifery and DHB). Workshops must meet the criteria outlined below.

All midwives must complete at least one Technical Skills Workshop in each three-year period. Midwives are responsible for meeting the costs of these workshops.

The **content** for the first Technical Skills Workshop (2005 – 2008) is as follows:

- Postnatal assessment of woman (to six weeks)
- Newborn assessment (to six weeks)
- Handover to well-child service (at four to six weeks)
- Perineal suturing and repair
- Intravenous cannulation (with scenario focus on hydration in labour and management of PPH)
- Shoulder dystocia
- Undiagnosed breech

Approval

The **criteria** for approval of Technical Skills Workshops are as follows:

1 Content is delivered over a two-day period or through two single days, but in this case each midwife must complete both days within three years.

2 Full course outlines are provided to the Midwifery Council. Course outlines will include the following:

- ✓ Course objectives
- ✓ Course plan (timetable)
- ✓ Content and reference list/evidence used in preparing content
- ✓ Description of scenario-based teaching strategies for each aspect of course, including how course will develop problem solving and critical thinking skills of participants
- ✓ List of type and amount of teaching resources and equipment available
- ✓ Description of all assessment procedures and marking criteria
- ✓ Example of certificate of achievement[8] to be provided to the midwife on successful completion
- ✓ List of pre-course reading

3 Content as defined by the Midwifery Council is covered in each workshop and if the workshops run over two days the course outline must show the content for each day and demonstrate that the midwife will cover all required content over both days.

4 New Zealand registered midwives with current Midwifery Practising Certificates, teaching preparation and experience, and up to date clinical skills, provide teaching. An appropriately qualified practitioner carries out any specialist teaching.

5 Content is based on Midwifery Council Competencies for Entry to the Register of Midwives, NZCOM Standards for Practice, NZCOM Consensus Statements, NZCOM Decision Points, New Zealand Guidelines Group guidelines, and Section 88 Maternity Notice.

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[8] Certificates must show that the title of the course is a Technical Skills Workshop in partial fulfilment of the Midwifery Council of New Zealand's Recertification Programme, and must state that "this programme has been approved by the Midwifery Council of New Zealand". Certificates must include the name of the education provider, the full name and Midwifery Council registration number of the midwife and the date of the course.

6 All teaching is based on recent and appropriate evidence.

7 Skills are taught through the use of clinical scenarios

8 Workshops focus on development of problem solving and critical thinking skills and evidence-based practice.

9 Pre-course reading material is provided.

10 Midwives have the opportunity for practising skills.

11 All skills are assessed through reliable and valid OSCE examinations. Assessment should test competence in the skill, the midwife's decision-making processes and her documentation.

12 Skills are assessed by skilled and experienced midwives and other qualified practitioners as appropriate. If workshops are run over two separate days the skills taught each day must be assessed on that day.

13 Appropriate equipment and resources are available for all participants.

14 Access to rural midwives is provided. (This may involve taking the programme out to other locations or finding other innovative and flexible ways of ensuring access for local rural midwives).

15 Education Providers retain records of attendance and successful completion of the full course (ensuring that if the course is run over two days that the provider can show that each participant has completed both days). These records include the full name, address and Midwifery Council registration number of each attendee.

16 Records of attendance and successful completion are forwarded to the Midwifery Council on completion of each course.

The **process** for approval of Technical Skills Workshops is as follows:

1. Approved Education Providers submit information about their course that demonstrates that the course will meet the criteria outlined above.
2. The Midwifery Council's Education Committee will assess the application against the criteria at the first available opportunity.
3. Any course that does not meet the criteria will be returned to the provider with a request for further information.
4. Courses that meet the criteria will be approved for a period of three years.

5. Once the course has been approved education providers can offer the course and can advertise that it has been approved by the Midwifery Council of New Zealand (see footnote on previous page in relation to the certificate for attendees).

Audit

The Midwifery Council will carry out random audits of the provision of Technical Skills Workshops to ensure that education providers are delivering the courses according to the approved course documentation.

8.3 Appendix Four: Portfolio requirements and points allocation

8.3.1 Evidence of ongoing education:

- Completes **compulsory** approved[9] ongoing education over three years:
    - Technical Skills Workshop (2 days) (complete at least once every three years)
    - Neonatal Resuscitation Update (approximately two hours) (complete every year)
    - Adult CPR Update (approximately two hours) (complete every year)
    - Breastfeeding workshop (half to one day) (complete at least once every three years)
- Minimum of 40 points of **elective** approved continuing education over three years, eg:
    - Midwifery Postgraduate programmes (per paper) (40 points)
    - NZCOM Smoke Change Programme (15 points)
    - NZCOM Family Violence Intervention Programme (15 points)
    - Polytechnic/University Midwifery Short Courses (eg. Preceptor/mentoring preparation; Assessment Skills; Evidence Based Practice; Portfolios; Interpretation of Lab Results; Newborn Assessment) (points to be allocated as approved)
    - DHB Midwifery Short Courses (eg. Breastfeeding Updates; Skills Updates) (points to be allocated as approved)
    - ALSO course (15 or 20 points)

[9] DHBs, NZCOM (national and regional), Polytechnic Schools of Midwifery, and University Schools of Midwifery will automatically be approved as education providers within the Recertification Programme. To ensure consistency and appropriate standards Education Providers will need to submit Technical Skills Workshops for approval against the criteria outlined in Appendix Three and breastfeeding workshops for approval against the criteria outlined in Appendix Four. Other elective continuing education courses must be submitted to the Council for approval and allocation of points.

- Polytechnic/University Pharmacology & Prescribing courses as approved for midwives registering form overseas (points to be allocated as approved)
- Prescribing Updates (points to be allocated as approved)
- 'Non-approved' education (10 points) (See below)
- Other courses as developed and approved

Education Providers are encouraged to develop on-line and distance continuing education programmes that will be accessible to midwives in rural and remote areas or others who do not have easy access to continuing education courses.

8.3.1.1 'Non approved' education

There will be an allocation of 10 points to 'non-approved' education. This means that the courses do not need to be approved by the Council and points will not be allocated. Examples of this type of education might include computer skills, small business workshops, adult teaching courses, Treaty of Waitangi Workshops, or education towards Lactation Consultant qualifications. It is expected that attendance at such courses would equate to at least two days in length. Midwives will be expected to include evidence of attendance in their portfolios as well as providing some written reflection on their learning from this education and how it has contributed to the midwife's professional development and competence. If midwives utilise 10 points in this way they will only need to complete another 30 points through approved elective continuing education courses over a three-year period. However, the 'non approved' 10 points is optional and midwives can use the whole 40 points through approved continuing education courses if they wish. It will depend on each individual's continuing education needs.

8.3.2 Evidence of ongoing professional activities

- 60 points of **professional activities** over three years. eg.

- Regular Supervision of midwifery students in long[10] placements (20 points per year)
- Regular supervision of midwifery students in medium[11] placements (15 points per year)
- Regular supervision of midwifery student in short[12] placements (10 points per year)
- Mentoring[13] of midwifery colleagues (20 points per year)
- Competence assessment[14] of overseas midwives seeking registration (20 points per assessment)
- Member of Midwifery Council Competence Review Panel[15] (40 points per assessment)
- Member of NZCOM Midwifery Standards Review Panel (30 points per annum)
- Member of NZCOM Resolutions Committee (20 points per annum)
- Expert witness for HDC, ACC, Coroners Court or HPDT (20 points per annum)
- DHB Clinical Career Pathway assessor or Professional Development Programme assessor (15 points per annum)
- Attending midwifery conferences (5 points per conference)

[10] Long placements are those where the student is placed one-to-one with an individual midwife for a period of six weeks or more and where the midwife is required to teach and to make assessment of the student's competence.
[11] Medium placements are where a student works on a one-to-one basis with a midwife for less than six weeks and where the midwife is required to teach and assess the student.
[12] Short placements are those where a student is following through one or more woman over a period of time but is not involved with the midwife on a daily basis or where core midwives are supervising students on hospital placements. In these cases the midwife may be required to give verbal feedback to the student's supervisor.
[13] Mentoring means entering a formal relationship with another midwifery colleague for a defined period of time for the purposes of support and guidance as the midwife colleague adjusts to a different practice context or to practice as a new practitioner
[14] Competence assessment of overseas midwives means formal request from the Midwifery Council for this assessment. It is carried out over a two - six week period and involves assessment against the Competencies for Entry the Register of Midwives.
[15] Competence Review means formal appointment by the Midwifery Council to carry out a review of a midwife's competence. The details of this process are available in a separate document.

- Attendance at regular perinatal mortality meetings (5 points per annum)
- Conducting clinical audits (15 points per audit)
- Evidence based policy and guideline development (15 points per guideline)
- BFHI Assessor (20 points per annum)
- Quality Health NZ auditor (20 points per annum)
- Presentation at seminars or formal teaching sessions (10 points per presentation)
- Informal teaching sessions for peers or students (5 points per session)
- Member of Midwifery Council Professional Conduct Committee (40 points per annum)
- Case presentations to colleagues (5 points per presentation)
- Presentation at conferences (15 points per presentation)
- Publications in midwifery journals/texts or other professional journals/texts (30 points per publication)
- Office holder as Union representative (15 points per annum)
- Office Bearer in NZCOM regional committee (15 points per annum)
- NZCOM Regional Chair or National Committee Member (30 points per anum)
- Other activities to be allocated points as identified.

Council recognises that any list of professional activities can never be complete and invites midwives to continue to make suggestions as to examples of professional activities that can be included, with rationale for their inclusion and suggestions as to points to be allocated to these activities. For example, midwives in rural areas may have less access to some of the activities currently listed. They might individually engage in updating knowledge through reading Journals or investigating a clinical issue through on-

line databases. These midwives could describe the activity and the professional development gained from it to the Council and have points allocated for the activity.

For all activities midwives will need to describe the activity and reflect on their learning and professional development in their portfolios.

8.3.3 Compulsory education

This will consist of the following:

1. Technical Skills Workshops. These two-day courses will be provided by approved education providers (preferably in collaboration with other approved providers where possible) and will enable midwives to update certain technical skills at least once every three years (see Appendix Three).
2. Neonatal resuscitation and adult CPR. Together these courses will be a minimum half-day. They are currently offered by DHBs and midwives must update these skills annually.
3. Breastfeeding Workshop. These courses will be from half to one day and can be provided by any approved education provider (see below). Midwives must attend at least once every three years.

8.3.3.1 Neonatal resuscitation updates and adult CPR updates

Council recognises that DHBs and other providers currently offer neonatal resuscitation updates and adult CPR updates. Any programmes offered by DHBs or other approved education providers, and that reflect the New Zealand context, will be accepted for this component of the Recertification Programme. Education providers will be asked to send an outline of their courses to the Council for approval and midwives will need to obtain some verification of attendance at these workshops as evidence for their portfolios. These workshops may vary slightly in length and may not necessarily have an assessment component. Where possible these courses will have a practical or 'hands on' component.

8.3.3.2 Breastfeeding Updates

Council recognises that DHBs and other providers currently offer breastfeeding updates. DHBs and other providers must submit details of their courses to the Midwifery Council for approval before they will be accepted for this component of the Recertification Programme (See Midwifery Council document 'Information for Education Providers, March 2005, available on website). The course details must include the following:

- ✓ Course objectives
- ✓ Course plan (timetable)
- ✓ Content and reference list/evidence used in preparing content
- ✓ Evidence that content reflects the New Zealand context, WHO 'Ten Steps to Successful Breastfeeding' and the Baby Friendly Hospital Initiative (New Zealand Breastfeeding Authority, 1999).
- ✓ Description of scenario-based and evidence-based teaching strategies
- ✓ Description of any 'hands on' practical component
- ✓ Evidence of how course will develop problem solving and critical thinking skills of the participants
- ✓ List of type and amount of teaching resources and equipment available
- ✓ Description of any assessment procedures and marking criteria
- ✓ Example of certificate to verify attendance or achievement (if assessed) by the midwife
- ✓ List or examples of any course reading supplied
- ✓ Details of how the course will be provided to rural midwives

By attending an adult CPR update each year, a neonatal resuscitation update every year and a technical skills workshop and breastfeeding workshop once every three years, midwives will meet the requirement for compulsory education every three years. Any midwives who wish to attend such updates/workshops more frequently can count these towards their elective continuing education requirements.

8.3.4 Elective continuing education

Elective continuing education courses must be submitted to the Midwifery Council for approval and for the allocation of points. Details of the criteria and process for approval of these course is outlined in the Midwifery Council document, 'Information for Education Providers', March 2005, which is available on the Midwifery Council website.

8.3.5 Guidelines for points allocation of elective continuing education and professional activities

Points will be allocated to elective continuing education courses and to professional activities as indicated above. Courses or professional activities that do not yet have points allocated must be submitted to the Midwifery Council with sufficient detailed information for the Council to allocate the points. Points will be allocated using the following criteria as a guide:

- Length of involvement of the midwife/length of course
- Degree of involvement/participation/preparation/formal training required of the midwife
- Assessment requirements versus attendance requirements
- Government health priorities
- Midwifery professional priorities
- Application/relevance to midwifery
- Contribution to midwifery knowledge and midwifery profession
- Relevance to and reflection of New Zealand midwifery context
- Courses run by New Zealand registered midwives
- Courses taught by midwives and others with appropriate expertise

8.4 Appendix Five: Access and Fees for NZCOM Midwifery Standards Review component of Recertification Programme

Access

NZCOM has given an undertaking to ensure its capacity to provide access to MSR for all midwives. A coordinator will manage the process at a national level, thus decreasing the voluntary work that has been undertaken in the regions to date. MSR Reviewers have committed to participation in a certain number of reviews each year and the College is continuing its training of these reviewers while also developing new reviewers. One aim is to increase the number of core midwives who are prepared to be reviewers.

Fee

NZCOM has identified the actual cost of each review as $450. Council is not in a position to meet this cost but will provide $100 subsidy for each review, bringing the cost to $350 per review. NZCOM has already committed to subsidising all core midwives by a further $100 for 2004 and 2005, and indeed approximately 100 core midwives have already taken up this offer and have been reviewed or are booked for review this year. In 2006 the core midwife fee returns to the normal level. This means that for 2004 to 2006 the costs of MSR to each midwife are as follows:

	Core midwife MSR fee	**LMC midwife MSR fee**
2004	$250	$350
2005	$250	$350
2006	$350	$350

NZCOM has entered into a formal written deed of undertaking with the Midwifery Council to hold the fees for conducting the Midwifery Standards Review Process on trust in a separate account. This will enable a separate and transparent accounting system, which will make sure that the fees collected will only be used to meet expenses incurred in conducting the MSR. This will also ensure that any surplus in any year will go back into the provision of MSR.

Further subsidies

As is its right NZCOM may decide to subsidise its own members in any way it wishes. Council understands that NZCOM will be doing this in recognition of the membership fees paid by members and their commitment to their professional organisation. Council understands that the subsidised fees for NZCOM members are as follows:

- LMC midwives $250
- Core midwives $150

DHB employers or other employers might also wish to subsidise the MSR fee for their employed midwives. Council understands that subsidy of the MSR fee has been agreed in DHB employment award negotiations with MERAS and NZNO in 2004/5 and that the topic is also being discussed with Polytechnic and University employers of midwifery teachers.

Booking your Midwifery Standards Review

Midwives will need to book their reviews with NZCOM. Information about this process will be available early in the 2005/6 APC year. Information will be posted on the Midwifery Council website and detailed in the Midwifery Council Newsletter.

Part Six: Conclusion

Part Six: Conclusion

This thesis set out to explore New Zealand midwifery's professional project in its development from workforce to profession. It was examined as a 'professional project' in order to present New Zealand midwifery, not as a 'given' or fixed concept, but as an individual entity brought into existence through the work of its members and situated in a particular historical, social and political context (Witz, 1992). Its meaning at any time depends on the network of social relations within which it is embedded and the way in which it is constituted, but a key meaning for New Zealand midwifery is that it has deliberately constituted itself as a profession in partnership with women. Midwifery partnership is a distinctly feminist form of professional practice because it uses gender as a resource and draws on feminist understandings *"about the importance of women taking control over their lives ...and their reproductive experiences in particular* [and puts] *feminist concerns about issues of responsibility, control, empowerment and choice...at the centre of midwifery's definition of itself as a profession"* (Tully, 1999, p.49).

Once the separate and distinct profession of midwifery again came into existence in New Zealand through legislative change and social and political mandate, its members have continued to maintain and strengthen its position. This strengthening has been a deliberate and planned policy of enacting a series of integrated professionalisation strategies. Consistent with New Zealand midwifery's overt underpinning philosophy, all of these strategies express partnership in practice, but each with a different priority for practice and with a different contribution to midwifery professionalism. As a profession is basically a socio-political construct it is never static and therefore is always vulnerable to change to its central tasks. As we have seen in part One, Chapter One of this thesis it is the exercise of these tasks and the philosophical position through which these tasks are expressed that differentiate professional groups (Abbott, 1988). There is also possible vulnerability to change in other professions with which they co-exist in a system of interdependence and competition. Therefore, in shaping and consolidating itself as a profession, midwifery is in constant interplay with external and internal forces such as state agencies, other professions and its own membership of midwives and women.

In concluding this thesis I will re-examine some theoretical understandings of professionalisation and draw on these theoretical perspectives in analysing how the four key professionalising strategies used by midwifery, have succeeded in taking midwifery from a workforce to a profession. These four strategies are partnership, leadership, education and regulation. Although they have been addressed separately in this thesis, these four strategies were of necessity integrated in their approach and enabled New Zealand midwifery to develop a unique professional public identity and private practice that is in partnership with women. By claiming partnership as central to our identity New Zealand midwifery has deliberately shifted power from midwives to women in order to redefine professionalism and midwifery.

> *When articulating midwifery as a partnership of equal status midwives have redefined the accepted view of professionalism. Instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that women can control childbirth. Midwifery must maintain its women-centred philosophy to ensure that its control of midwifery never leads to control of childbirth* (Guilliland & Pairman, 1995, p.49).

By working in more egalitarian relationships with women, midwifery has drawn on notions of 'new professionalism' whereby knowledge is constructed as an outcome of the relationship between midwives and women, power is shared and gender is used a resource in our ongoing professional project (Freidson, 1994; Page, 2003; Colyer, 2004).

I will turn now to a brief re-examination of the notion of 'professional project' having provided the reader with insight into the detail of these chosen professionalising strategies and the experience of their expression through multiple but differently shaded publicly directed portfolio pieces.

New Zealand midwifery's professional project

The notion of 'professional project' has been used by both Larson (1977) and Freidson (1983) as a way of examining professions as both concrete and historically bound empirical entities. Professional projects are strategies of occupational closure whereby occupations

seek to establish a monopoly over certain skills and competencies in order to enhance their market value and thereby gain control over that area of work (Larson, 1977; Freidson, 1983). The term 'strategy' implies a process, but Witz (1992) contends that there is always interplay between strategy and structure or between actions and resources for actions. Power is a built-in attribute of occupational closure. In other words there is a one-sided emphasis on the exercise of power that Witz critiques as gender-blind because it does not make overt the mere possession of power by dominant groups. The strategies used by women engaged in professional projects have differential access to tactical means of achieving occupational closure because of their restricted access to resources as a result of institutionalised patriarchal control.

Larson (1977) identified two main strategies for professions attempting to secure occupational closure. These are credentialist strategies and legalistic strategies. Credentialist strategies involve securing a structural linkage between a profession and its knowledge base or, in other words, between knowledge and power. Credentialist strategies use qualifications and accreditation as means by which to restrict access to certain occupations. Legalistic strategies are those that seek state support and legal monopoly through state mechanisms such as registration and licensure (Johnson, 1972).

The defining features of professional projects are that they pursue occupational monopoly, or closure, through legalistic and credentialist professionalisation strategies. Heteronomous means of professionalisation are those accessed through the institutional arena of the state, in other words, legalistic strategies such as the 1971 Nurses Act that established the Nursing Council as the regulatory authority for nurses and midwives. Autonomous means of professionalisation are those created and controlled by the occupational group themselves or through relationships with societal institutions such as universities, and are therefore credentialist strategies. For example, the College's establishment of standards for practice and a code of ethics with which members are expected to adhere (Larson, 1977).

However, as mentioned above, Witz (1992) contends that the patriarchal structuring of both state and societal institutions has denied women access to these means of closure, even in

the 20th century, and that the patriarchal nature of these state and social institutions imposed severe restrictions on women's ability to engage in professional projects. Consequently, as Witz explained in her case study of British midwives, (see Chapter One of this thesis) attempts to gain state registration in the late 19th and early 20th century, forced women to mobilise proxy male power to represent their interests and to accept medical control of their regulatory processes when they did succeed in gaining state registration. In the same way patriarchal control of universities and their exclusion of women meant that female occupations had to utilise other institutional locations, such as hospitals, for sites of their education and training programmes. Female professional projects relied on male support and intervention, although, as Witz suggests, the very act of organising collectively and engaging in a professional project, is in itself liberating. While the way that men dominate varies across time as a result of historic and cultural constructions of male power, the patriarchy remains central in shaping workplaces, as evidenced in health care both administratively and professionally.

Strategies of occupational closure must therefore be examined from the perspective of gender because men and women have different access to resources to achieve their aims in a patriarchal society where male power is institutionalised and organised (Witz, 1992). Women have not had the same access as men to resources of power and therefore they have developed their strategies of occupational closure, or professionalisation, differently to men.

As seen in Chapter One of this thesis, Witz (1992) offers a model of gendered strategies of occupational closure as a way of explaining the different ways that men and women engage in professional projects. She makes a four-fold distinction between strategies of exclusionary, inclusionary, demarcationary and dual closure. Exclusionary and demarcationary strategies are engaged in by the dominant social or occupational group, whilst inclusionary and dual closure strategies describe the responses of the subordinate social or occupational group.

So what relevance have we seen of these theoretical explanations of professionalisation strategies to New Zealand midwifery's professional project?

This thesis set out to chronicle the development of the midwifery profession in New Zealand through the exploration of four key professionalising strategies that I argued led midwifery from a workforce to a profession. These strategies are partnership relationships with women; leadership through the professional organisation; education for midwifery autonomy; and self-regulation within midwifery professional frameworks. In bringing closure to this thesis I discuss the integration of these processes for two stages in midwifery's professional project; seeking occupational closure and strengthening occupational closure, and make the case that it is the coherent integration of these four strategies that has led to midwifery's success in gaining domination over primary childbirth services in New Zealand.

Seeking occupational closure

Midwifery as profession was brought into existence as a result of a political struggle with both medicine and nursing. As we have seen, midwifery could only be defined as workforce in the early 1980s because it had no legal authority for autonomous practice, no professional identity, no specific education programme, and no independent professional organisation to represent its views.

Instead midwifery's work was in carrying out delegated tasks on behalf of medicine; its professional identity had become subsumed into nursing as 'obstetric nurse'; and the Midwives Section, as a sub-group of the New Zealand Nurses Association, was constrained constitutionally from promoting any opinion publicly that was at variance to the parent body.

Medicine used demarcationary strategies to control midwifery by defining midwifery's tasks and supervising midwifery's practice. In this way midwifery worked in a subservient and 'hand maiden' role in relation to medicine and as a result much of midwifery's own

knowledge and understandings of birth were lost as they were mediated by the ideology of another discipline, medicine. Nursing too, controlled midwifery through its jurisdiction over heteronomous means of closure such as midwifery registration and midwifery education.

It was midwifery's dual closure response to medicine's demarcationary strategies of control through the simultaneous strategies of resistance and exclusion that led to the reinstatement of midwifery autonomy. This response took place in a particular time in history and in a particular social and political climate in which the interplay of a number of factors aided midwifery's dual closure response.

Midwifery's dual closure response had both usurpationary and exclusionary elements. The usurpationary response was to resist medicine's efforts to force midwives to act like obstetric nurses. While medicine defined the tasks of midwifery, it remained reliant on midwifery to self-enforce these controls. As doctors' modes of general practice did not allow them to be present in the maternity hospital all of the time, they were reliant on midwifery assessments to inform them of women's progress in labour. In many ways, therefore, midwives controlled the boundaries of practice between themselves and doctors, and they used this power to resist medical control. In their daily practice midwives continued to make some autonomous decisions. For instance, midwives continued to make assessment about women's progress, particularly in relation to labour and birth and the postnatal period, and chose when to inform a doctor that a birth was imminent. Thus they could, and did, act subversively to undermine and resist medical control. Indeed, midwifery later argued at the Social Services Select Committee hearings into the 1990 Nurses Amendment Bill, that they were already autonomous 'in practice' and that this needed to be ratified 'in law'. Doctors disagreed, but by then midwifery had some powerful allies, particularly in various consumer groups, and their claim of expertise over normal birth was upheld.

The exclusionary element of midwifery's dual closure response was to construct a professional identity that was separate to nursing and use this to claim expertise in normal

childbirth. On the basis of this midwifery expertise midwives argued the exclusion of nurses from maternity services, although this took several years to take effect.

Of course these processes were not linear and they occurred over a number of years. However, in the 1980s midwives and women became allies in their common cause to reinstate midwifery autonomy; a women's agenda was given priority by government; and the report of the Cervical Cancer Inquiry at National Women's Hospital in Auckland put patient's rights to information, choice and decision-making power high on the political agenda (Committee of Inquiry, 1988). This Cervical Cancer Inquiry also impacted negatively on medicine, leading to some decrease in its power, at least in the short term, because of the public perception that medicine had abused its position of power and authority and trust. As a result medicine has also engaged in processes to redefine itself as a profession, and it too, has drawn on understandings of 'new professionalism' (Health Workforce Advisory Committee, 2005).

Thus it was a combination of factors such as midwives and women uniting in a campaign for change; a government agenda of equity for women and a social context that demanded a new style of professionalism, that led to midwifery's success in regaining professional status in 1990. The political campaign and the support of women had legitimated midwifery practice for those who met the state registration requirements. By 1990 midwifery had a social mandate to provide autonomous midwifery care in the area of 'normal' childbirth and a newly formed professional organisation to promote midwifery's interests and to lead its next stage of professionalisation. However, midwifery's education processes remained under nursing control, and the regulatory responsibilities remained with the Nursing Council of New Zealand. The imperative, therefore, was for midwifery to embark on a further process of professionalisation in order to gain full professional status and determine its own destiny.

Strengthening occupational closure

By 1990 New Zealand midwifery had a social mandate for autonomous practice expressed through legislation, a strong base of consumer support, and a fledgling professional organisation to provide leadership. It had also constituted its professional identity as an autonomous profession but one that worked in partnership with women. Partnership defines midwifery's professional relationship with women and this notion of midwifery as partnership with women underpins midwifery professionalism, then and now.

The first imperative of the College was to ensure that this foundational philosophy of partnership with women was put into practice in all its professionalising strategies. Thus midwifery has deliberately structured the College to value and practise partnership in all aspects of the organisation including policy development, professional activities and the development of midwifery professionalism. From this base the College has used its professionalising strategies in order to: ensure a secure funding base and maternity service framework to support autonomous midwifery practice that is provided in partnership with women; ensure midwifery education programmes for entry to the profession and postgraduate programmes to assist the articulation of developing midwifery knowledge; achieve self-regulation so as to attain full professional status. Each of these was necessary if the College was to ensure an integrated professional and regulatory framework that would support midwifery autonomy and midwifery partnership practice into the future.

The four professionalising strategies that have been explored in this thesis have been crucial to midwifery's success to date. Midwifery is now a strong profession. It is the dominant provider of primary maternity services and it no longer faces immediate competition from general practice as midwives are now the Lead Maternity Carers to over 78% of childbearing women and most General Practitioners have chosen to discontinue offering maternity services (New Zealand Health Information Service, 2005). While New Zealand has not yet achieved a nationally consistent and comprehensive system for the collection and analysis of outcome statistics in relation to women and babies in the maternity services, there are signs that midwifery is improving the experience for women, providing safe care for mothers and babies, and that New Zealand's levels of intervention in maternity care are not increasing as rapidly as in other

countries such as Australia where midwifery does not have a lead role in the provision of care (Guilliland, Tracy & Thorogood, in press).

In New Zealand rates of exclusive breastfeeding continue to improve and immunisation rates at six weeks are high. Instrumental vaginal births have decreased from 11.8% in 1997 to 9.9% in 2003; inductions of labour have decreased from 22.1% in 1997 to 20.1% in 2003; and epidural analgesia has only marginally increased from 23.3% in 1997 to 24.4% in 2003 (Ministry of Health, 1999a, 1999b; New Zealand Health Information Services, 2003, 2004, 2005). Midwives have higher rates of normal vaginal births and lower rates for caesarian section, instrumental births, episiotomy, and epidural than general practitioners and obstetricians. Stillbirth rates are the same as general practitioners and overall there is a continuing decline in perinatal mortality, significant decrease in Sudden Infant Death (SIDS), decreased antenatal admissions for serious complications and a sustained decrease in admissions of very sick babies to neonatal intensive care (New Zealand Health Information Services, 2003, 2004, 2005). Furthermore, recent trend research from 1980-2001 confirmed markedly decreased rates of small for gestational age babies for Maori, Pacific Island and lower socio economic groups of women (Mantell et al, 2004). Although the gap between Maori and Pakeha baby outcomes in relation to prematurity remains unacceptably high, it appears that Maori rates have improved. Teenage pregnancy is slowly decreasing and outcomes for young Maori women have also improved over these years. Maori, young women and women from lower socio economic groups are more likely to choose a midwife for their LMC (New Zealand Health Information Services, 2003). Women's satisfaction with maternity services has increased over three national surveys (Ministry of Health, 1999, 2003, 2004) as has the intensity of that satisfaction.

While these outcomes are promising there is more work to do in exploring the multi-factorial causes of the increasing rates of intervention, particularly caesarian section, that are now a phenomenon of western maternity services. New Zealand midwifery is in a unique position to attempt to identify the ways in which midwifery care might impact on women's experiences of childbirth and the outcomes for woman and babies of midwifery-led care. It is likely that any challenge to midwifery's current dominance in maternity services in New Zealand will focus on

the results that midwifery can produce, and we will need to show at least that our care is safe and that our outcomes are as good as or better than those of general practitioners and obstetricians.

As Abbott (1988) shows us, professions are in a constant state of flux as they move and shift in response to each other in an interconnecting web of relationships. Today's temporary stability may be tomorrow's instability and midwifery needs to be vigilant to understand the potential interplay of external and internal forces and their impact on our continuing professional project.

In attaining midwifery autonomy through occupational closure, and in strengthening and consolidating midwifery professionalism through the integration of four professionalising strategies, it is important to recognise the historically specific process of this collective work on the part of midwifery. This has not been an idealised model of occupational development. Rather, it is a story of a specific group of women, at a specific time in history. Midwifery's professional identity and professional status are strong but not secure. We face a number of external and internal challenges in relation to: possible devolution of funding to Primary Health Organisations; possible rationalisation and amalgamation of midwifery schools; possible loss of membership because of the costs of self-regulation for a small profession; possible destabilisation of the profession if it becomes conventional and loses its strategic leadership and united vision; the impact of societal attitudes to childbirth and technology with the resulting international increase in intervention in childbirth ; and the impact of gender on societal perceptions and trust in a women's profession . Whether these external and internal challenges become threats or opportunities remains to be seen.

What does seem clear is that New Zealand midwifery's greatest strength is in its unique model of partnership with women. Partnership is expressed through all midwifery's professionalising strategies, and it is the internal consistency of midwifery's philosophical foundation of partnership, with the consistent expression of partnership in all dimensions of practice, that defines New Zealand midwifery's unique contribution.

Back to the beginning

This thesis set out to explore how New Zealand midwifery used four integrated professionalising strategies to take midwifery from workforce to profession and this objective has been achieved.

What this exploration of New Zealand midwifery's professional project has shown is that New Zealand midwifery's claim that midwifery *is* the partnership between midwives and women, and the congruence of this expression of partnership in practice, policy, education, politics and regulation defines the unique contribution of New Zealand midwifery both to women and to the wider international midwifery community.

This thesis has:

- Documented how changes to midwifery autonomy and midwifery's unique model of practice have fundamentally changed the structure of the whole maternity service, and brought it to the midwife-led and women-centred service it is today;
- Shown how an organisation, the New Zealand College of Midwives, has developed itself from a fledgling organisation to a fully functioning, mature and strategic organisation;
- Documented how midwifery education has been used as a tool for midwifery professionalism in developing a midwifery profession that works in partnership with women and promotes midwifery-led care;
- Shown how self-regulation within professional frameworks can both protect public safety and enhance midwifery professionalism;
- Provided a framework of four strategies within which the development of midwifery in New Zealand over the last twenty years can be understood;
- Demonstrated that these four professionalising strategies are a multi-pronged approach. It was the combined and integrated use of these four strategies that has led to midwifery's success and midwifery's continued development relies on the continuation and consolidation of each of these strategies.

This thesis reflects all the professional movement described above, but also reflects much more than this. The portfolio pieces demonstrate the various forms of writing and speaking which have been parts of our interaction with the public in naming and claiming midwifery in this professionalising project. But embedded in this have been my own professional activities which are a critical part of a professional doctorate.

Since enrolling in this professional doctorate in 1999 my actions within my professional positions as executive member of the College, senior educator and manager in a school of midwifery, member of the Nursing Council regulatory body, and now chair of the newly created Midwifery Council of New Zealand, have all been part of this doctorate. They have all been undertaken in interaction with the academic discipline of thinking and writing of this doctorate, each in interplay with the other. The changes in practice I have influenced in this period are as much a product of this professional doctorate as the work appearing in this written form – this thesis. The practice change is uniquely New Zealand but its documentation and dissemination belongs to women, midwives and others internationally.

New Zealand midwifery's example is of benefit elsewhere. Unlike other countries, such as Canada, where midwives have recently gained professional status and where professionalisation has moved midwives away from women and to a less egalitarian form of practice (Bouregault 2000), I argue the opposite. By defining midwifery as partnership and integrating partnership into all of our professionalising activities, New Zealand midwifery reinforces egalitarianism and brings midwives and women together in a partnership that is enduring and unique.

References

References

Abbott, A. (1988). *The system of professions. An essay on the division of expert labor.* Chicago: The University of Chicago Press Ltd.

Abbott, A. & Wallace, (1990). *The sociology of the caring professions.* London: The Falmer Press.

Barnett, J. R., Barnett, P. & Kearns, R. (1998). Declining professional dominance? Trends in the proletarianisation of primary care in New Zealand. *Social Science Medicine, 46,* (2), 193-207.

Board of Health Maternity Services Committee. (1979). *Obstetrics and the winds of change.* Wellington: Author.

Board of Health Maternity Services Committee. (1982). *Mother and baby at home: the early days.* Wellington: Author.

Bonham, D. G. (1983). *Whither obstetrics.* University of Auckland. Unpublished paper.

Broadbent, J, Dietrich, M, & Roberts, J. (1997). *The end of professions? The restructuring of professional work.* London & New York: Routledge.

Burrage, M. (1990). Introduction: the professions in sociology and history. In .M. Burrage & R. Torstendahl (Eds). *Professions in theory and history.* London: Sage Publications.

Calnan, M. & Williams, S. (1995). Challenges to professional autonomy in the United Kingdom? The perceptions of general practitioners. *International Journal of Health Services, 25,* 219-241.

Campbell, N. (2004). Doing nothing is no longer an option – professional development for midwives. *New Zealand College of Midwives Journal, 34,* 11, 29.

Coburn, D., Rappolt, S, & Bourgeault, I. (1997). Decline vs. retention of medical power through restratification: an examination of the Ontario case. *Sociology of Health & Illness, 19,* (1), 1-22.

Cohen, H. A. (1981). *The nurses quest for a professional identity.* Menlo Park, California: Addison-Wesley Publishing Company.

Coles, C. (2002). Developing professional judgment. *The Journal of Continuing Education in the Health Professions,* (22), 3-10.

Colyer, H. (2004). The construction and development of health professions: where will it end? *Journal of Advanced Nursing, 48,* (4), 406-412.

Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters. (1988). *The report of the Cervical Cancer Inquiry 1988.* Auckland: Government Printing Office.

Coney, S. (1993). Standing in the sunshine: a history of New Zealand women since they won the vote. Auckland: Penguin Books (NZ) Ltd.

Coopers & Lybrand. (1993). *First steps towards an integrated maternity services framework. A report by Coopers & Lybrand for the New Zealand Regional health Authorities.* Author.

Cruess, R, Cruess, S. & Johnston, S. (2000). Professionalism: an ideal to be sustained. *The Lancet, 356 (9224),* pp. 156 – 159.

Davis, D. & McIntosh, C. (in press). Partnership in education: the involvement of service users in one midwifery programme in New Zealand. *Nurse Education in Practice.*

Davies, C. (1995a). *Gender and the professional predicament in nursing.* Buckingham: Open University Press.

Davies, C. (1995b). Competence versus care? Gender and caring revisited. *Acta Sociologica, 38,* 17-31.

Davies, C (1996). The sociology of professions and the profession of gender. *Sociology, 30 (4),* 661-678.

Deitrich, M, & Roberts, J. (1997). Beyond the economics of professionalism. In Broadbent, J, Dietrich, M, & Roberts, J. (1997). *The end of professions? The restructuring of professional work.* London & New York: Routledge.

Department of Health. (1987). *Minutes of meeting of Working Party on Midwifery, Bridging and Related Courses 29/10.87.* Unpublished.

Department of Health (1988a). *Circular memorandum 28 April: Post basic eduction for midwives.* Unpublished.

Department of Health (1988b). *Circular memorandum 13 October: Polytechnic short courses and separate midwifery for registration.* Unpublished.

Department of Health. (1990). *Draft Policy Paper Reviewing the Nurses Act 1977.* Department of Health)

Department of Health. (1997). *Reform of Health Sector Occupational Regulation Statutes.* Department of Health.

Dobbie, M. (1990). The trouble with women. The story of Parents Centre New Zealand. Whatamongo Bay: Cape Catley Ltd.

Donnison, J. (1977). *Midwives and medical men: a history of interprofessional rivalries and women's rights.* London: Heinemann Educational Books.

Donley, J. (1986). *Save the midwife.* Auckland: New Women's Press.

Donley, J. (1987). *Has the NZNA served the interests of midwives?* Unpublished paper.

Donley, J. (1989). Professionalism. The importance of consumer control over childbirth. *New Zealand College of Midwives Journal,* September, pp. 6-7.

Downe, S. & McCourt. (2004).From being to becoming: reconstructing childbirth knowledges. In. S. Downe (Ed). *Normal childbirth: evidence and debate.* London: Churchill Livingstone.

Durie, M. (1998). *Whaiora Maori health development,* 2nd ed. Auckland: Oxford University Press.

Elliot, P. (1972). *The sociology of the professions.* London: Macmillan.

Ehrenreich, B. & English, D. (1973). *Witches, midwives and nurses.* London: Writers and Readers Publishing Cooperative.

Eldridge Wheeler, C. & Chinn, P. (1991) *Peace and power: a handbook of feminist process.* New York: National League for Nursing.

Etzioni, A. (1964). *Modern Organisations.* Englewood Cliffs, New Jersey: Prentice Hall.

Etzioni, A. (Ed). (1967). *The semi-professions and their organisation.* New York: The Free Press.

Faison, K. (2003). Professionalization in a distance learning setting. *The Association of Black Nursing Faculty Journal,* July/August, 83-85.

Fleming, V. (2000). The midwifery partnership in New Zealand: past history or a new way forward? In M. Kirkham (Ed). *The midwife-mother relationship.* London: Macmillan Press, 193 – 205.

Freeman, L., Timperley, H. & Adair, V. (2004). Partnership in midwifery care in New Zealand. *Midwifery, 20,* 2 – 14.

Freidson, E. (1970). *Professional dominance: the social structure of medicine.* New York: Atherton Press.

Freidson, E. (1983). The theory of professions: state of the art. In R. Dingwall and P. Lewis (eds). *The sociology of the professions,* London: Macmillan.

Freidson, E. (1986). *Professional powers: a study of the institutionalisation of formal knowledge.* Chicago: University of Chicago Press.

Freidson, E. (1994). *Professionalism reborn: theory, prophecy, and policy.* Chicago: The University of Chicago Press.

Freidson, E. (2001). *Professionalism: the third logic.* Chicago: The University of Chicago Press.

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms.* Wellington: Victoria University of Wellington.

Guilliland, K. (1989). Maintaining the links. A history of the formation of the NZCOM. *New Zealand College of Midwives Journal,* September, p. 14.

Guilliland, K. & Pairman, S. (1993). International Confederation of Midwives – 23rd triennial congress, Vancouver, Canada. *New Zealand College of Midwives Journal,(9),* October, 5-8.

Guilliland, K., & Pairman, S. (1995). *The Midwifery Partnership: A Model for Practice.* Monograph Series 95/1, Department of Nursing and Midwifery, Victoria University of Wellington.

Guilliland, K. & Pairman, S. (1996). ICM Oslo Congress report. *New Zealand College of Midwives National Newsletter,* August, 11-14.

Guilliland, K. (1998). *A demographic profile of independent (self-employed) midwives in New Zealand Aotearoa.* Unpublished master's thesis. Victoria University of Wellington.

Guilliland, K. (1999). The 25th triennial congress of the ICM. *New Zealand College of Midwives National Newsletter,(13),* July, 5-6.

Guilliland, K. (2004). A hundred years of midwifery and what have we learnt about ourselves? *Midwifery News,* October, 4-6, 28-29.

Guilliland and Pairman. (forthcoming). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service.* Christchurch: New Zealand College of Midwives.

Guilliland, K, Tracy, S. & Thorogood, C. (In Press). Australian and New Zealand health and maternity services. In. S. Pairman, J. Pincombe, C. Thorogood & S. Tracy. *Midwifery: preparation for practice.* Sydney: Elsevier Churchill Livingstone.

Halford, S, Savage, M. & Witz, A. (1997). *Gender, careers and organisations.* Houndmills: Macmillan Press.

Harding, D. (2000). Making choices in childbirth. In L. Page. (Ed). *The New Midwifery: science and sensitivity in practice.* London: Harcourt Publishers, 71 – 85.

Haug, M. (1975). The deprofessionalization of everyone? *Sociological Focus, 8, (3),* 197-213.

Health and Disability Commissioner Act 1994 [NZ]

Health and Disability Services Code of Consumer Rights, 1996 [NZ]

Health Practitioners Competence Assurance Act 2003 [NZ]

Health Workforce Advisory Committee. (2005). *Fit for purpose and for practice. A review of the medical workforce in New Zealand.* Wellington: Author.

Hill, A. (1982*). The history of midwifery from 1840 to 1979, with a specific reference to the training and education of the student midwife.* Unpublished MA thesis, University of Auckland.

Hoyle, E. (2001). Teaching as a profession. *International Encyclopaedia of the Social and Behavioural Sciences.* 15472-15476.

Illich, I., Zola, I., McKnight, J., Caplan, J. & Shaiken, H. (1977). *Disabling professions.* London: Marion Boyars Publishers Ltd.

Jarvis, P. (1983). *Professional education.* London: Croom Helm.

Johnson, T. (1972). *Professions and power.* London: Macmillan.

Kaufman, T. (2004). Introducing feminism. In M. Stewart. (Ed) *Pregnancy, birth and maternity care. Feminist perspectives.* Edinburgh: Books for Midwives, 1-10.

Katz Rothman B. 1984. Childbirth management and medical monopoly: midwifery as (almost) a profession. *Journal of Nurse-Midwifery, 29,* (5), 300 – 306.

Katz Rothman, B. (1991). *In labour: women and power in the birthplace.* New York: W.W. Norton & Company.

Kedgley, S. (1996). *Mum's the word. The untold story of motherhood in New Zealand.* Auckland: Random House New Zealand Ltd.

Kennedy, H.P. (1995). The essence of nurse-midwifery care: the woman's story. *Journal of Nurse-Midwifery, 40,* (5), September/October, 410 – 417.

Kennedy, H. P. (2000). A model of exemplary practice: results of a Delphi study. *Journal of Midwifery & Women's Health, 45, (1), 4-19.*

Kennedy, H.P. (2002). The midwife as an 'instrument' of care. *American Journal of Public Health, 92,* (11), 1759 – 1760.

Kennedy, H. P. (2004). The landscape of caring for women: a narrative study of midwifery practice. *Journal of Midwifery & Women's Health, 49,* (1), 4-19.

Kennedy, S. & Taylor, A. (1987). *An evaluation of Advanced Diploma in Nursing courses.* Wellington: Department of Education.

Kirkham, M. (Ed). (2000). *The midwife-mother relationship.* London: Macmillan Press.

Lambie, M. (1956). *My story. Memoirs of a New Zealand Nurse.* Christchurch: N. M. Peryer Ltd.

Lane, K. (2002). Midwifery: a profession in transition. *Australian Journal of Midwifery, 15 (2),* 26-31.

Larson, M. (1977). *The rise of professionalism.* California: University of California Press.

Larson, M. S. (2003). Professionalism: the Third Logic. *Perspectives in Biology and Medicine;* Summer, 46, 3, Health Module, 458 – 462.

Leap, N. & Hunter, B. (1993). *The midwife's tale. An oral history from handywoman to professional midwife.* London: Scarlet Press.

Leap, N. (2000). The less we do, the more we give. In M. Kirkham.(Ed). *The midwife-mother relationship.* Houndmills: Macmillan Press.

Mantell, C.D., Craig ,E.D.,Stewart, A.W., Ekeroma, A.J., Mitchell, E.A.(2004) Ethnicity and Birth outcome: New Zealand Trends 1980-2001. Part 2 Pregnancy outcomes for Maori Women, *Australian and New Zealand Journal of Obstetrics and Gynaecology, 44,* 537-540.

Marshall, B. & Witz, A. (Eds). *Engendering the social. Feminist encounters with sociological theory.* Maidenhead: Open University Press.

McCourt, C. & Page, L. *Report on evaluation of one –to- one midwifery.* London: Thames Valley University, Centre for Midwifery Practice.

McKendry, R. & Langford, T. (2001). Legalized, regulated, but unfunded: midwifery's laborious professionalization in Alberta, Canada, 1975 – 99. *Social Science & Medicine, 53,* 531-542.

McKnight, J. (1977). Professionalised service and disabling help. In. Illich, I., Zola, I., McKnight, J., Caplan, J. & Shaiken, H. (1977). *Disabling professions.* London: Marion Boyars Publishers Ltd.

Mein-Smith, P. 1986, *Maternity in Dispute. New Zealand 1920 – 1939.* Historical Publications Branch Department of Internal Affairs, Wellington.

Members of New Zealand's first Midwifery Council. (2004). *Midwifery News, 32, March.* New Zealand College of Midwives, 6-7.

Midwifery Council of New Zealand. (2004a). *Midpoint,* September 2004, Midwifery Council of New Zealand.

Midwifery Council of New Zealand (2004b). *Midpoint,* December 2004, Midwifery Council of New Zealand.

Midwives Act 1904 [NZ]

Midwives Section. (1984). *Report of the working party looking into education for the role, scope and sphere of practice for the midwife in New Zealand.* Wellington: NZNA.

Midwives Section. (1986) *Minutes of Annual General Meeting 9/4/86.* Unpublished.

Midwives Section (1987a). *Submission on future of midwifery education in New Zealand.* Unpublished.

Midwives Section. (1987b). *Minutes of Annual General Meeting 23/9/87.* Unpublished.

Midwives Section (1988b). *Minutes of National Midwives Section meeting 4/8/88.* Unpublished.

Ministers of Health, Education and Women's Affairs. (1987). *Press release: Changes to midwife training 7/12/87.*

Ministry of Women's Affairs (1989). *Women's Health. What needs to change? A summary of the recommendations of the Cervical Cancer Inquiry and a practical guide to action.* Wellington: Author.

Ministry of Health. (1999a). *Obstetric Procedures, 1998/99-1997/8,* Wellington: Ministry of Health.

Ministry of Health. (1999b). *Report on Maternity: Maternal and Newborn Information,* Wellington: Ministry of Health.

Ministry of Health. (2002).*Maternity Services Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000.* Wellington: Ministry of Health.

Ministry of Health. (2003). *Maternity services consumer satisfaction survey.* Wellington: Author.

Ministry of Health. (2004a). *Discussion Document on Restricted Activities under the HPCA Act 2003*, August. Wellington: Author.

Ministry of Health. (2004b). *Fetal and infant deaths 2000.* Wellington: Ministry of Health

Neill, J.O.C. (1961). *Grace Neill. The history of a noble woman.* Christchurch: N.M. Peryer Ltd.

New Zealand College of Midwives. (1989a). *Minutes of National Committee meeting 29/10/89.*

New Zealand College of Midwives. (1989b). *Minutes of inaugural Annual General Meeting 2/4/89.*

New Zealand College of Midwives. (1989c). *Newsletter, May.* Unpublished.

New Zealand College of Midwives. (1990a). *Annual Report 1989 – 1990.* Unpublished.

New Zealand College of Midwives. 1990b. Direct entry midwifery update. *Newsletter*, 2, (5), February, p.11.

New Zealand College of Midwives. 1992. A framework for Midwifery Education. *Report on Education Workshop, February 1992, Wellington.* Christchurch: NZCOM.

New Zealand College of Midwives. (1992). *Midwives Handbook for Practice.* Author.

New Zealand College of Midwives. (1993). *Midwives Handbook for Practice.* Christchurch: Author

New Zealand College of Midwives. 1994. *Education Workshop Discussion Papers, Palmerston North, May 1994.* Christchurch: NZCOM.

New Zealand College of Midwives. (2002). *Midwives Handbook for Practice.* Christchurch: Author

New Zealand College of Midwives. (2004). *Midwifery Standards Review handbook.* Christchurch: Author

New Zealand College of Midwives. (2005). *Midwives handbook for practice.* Christchurch: Author.

New Zealand Health Information Service. (2003). *Report on Maternity 2000 and 2001.* Wellington, Ministry of Health.

New Zealand Health Information Service. (2004). *Report on Maternity 2002.* Wellington: Ministry of Health.

New Zealand Health Information Service. (2005). *Draft Report on Maternity: Maternal and Newborn Information, 2003*, Wellington: Ministry of Health.

New Zealand Nurses Association. (1981). *Policy statement on maternal and infant nursing.* Wellington: Author.

New Zealand Nurses Association. (1984). *Nursing education in New Zealand. A review and a statement of policy.* Wellington: Author.

New Zealand Nurses Association. (1987a). *An evaluation of the Advanced diploma in Nursing courses (Department of Education). What is to be done? NZNA comments on the report.* Unpublished paper.

New Zealand Nurses Association. (1987b). *Annual Report 1987.* Unpublished.

New Zealand Nurses Association. (1988). *Annual Report 1988.* Unpublished.

New Zealand Nurses Association. (1989). *Midwifery Policy Statement.* Wellington: Author.

Nurses and Midwives Registration Act 1925. [NZ]

Nurses Act 1971 [NZ]

Nurses Amendment Act 1983 [NZ]

Nurses Amendment Act 1990 [NZ]

Nursing Council of New Zealand. (1978). *Summary of work undertaken by the Education Committee on behalf of Council for the period 1972 – 1978.* Unpublished Report.

Nursing Council of New Zealand. (1988). *Circular letter 1988/14. Standards and criteria for registration of midwives.* Unpublished.

Oakley, A. & Houd, S. (1990). *Helpers in childbirth. Midwifery today.* London : Hemisphere Publishing Company on behalf of the World Health Organisation.

Otago Polytechnic. (1989). *Southern Region Midwifery Curriculum.*

Otago Polytechnic (1991). *Bachelor of Midwifery curriculum document.*

Oxford Dictionary. (1961). Oxford: Clarendon Press.

Page, L. (2003). One-to-one midwifery: restoring the 'with woman' relationship in midwifery. *Journal of Midwifery and Women's Health, 48 (2),* 119-125.

Pairman, S. 1991. A framework for midwifery education. *New Zealand College of Midwives Journal,* May, 7-9.

Pairman, S. (1998a). *The Midwifery partnership: an exploration of the midwife/woman relationship.* Unpublished masters thesis, Victoria University of Wellington.

Pairman, S. (1998b). Developing and crafting a vision: a strategic plan for midwifery. *New Zealand College of Midwives Journal, 18,* 5 – 9.

Pairman, S. (2000). New Zealand College of Midwives Education Framework 1999. *New Zealand College of Midwives Journal, 22,* June, 5 –14.

Pairman, S. (2001). International trends and partnerships in midwifery education. *New Zealand College of Midwives Journal, 24,* 7-9.

Pairman, S. (2002). Towards self-determination: the separation of the midwifery and nursing professions in New Zealand. In E. Papps (Ed.) *Nursing in New Zealand. Critical issues; Different perspectives.* Auckland: Pearson Education New Zealand Ltd.

Pairman, S. & Guilliland, K. (2003). Developing a midwife-led maternity service: the New Zealand experience. In. M. Kirkham. (Ed). *Birth Centres. A social model for maternity care.* London: Books for Midwives.

Pairman. S. & Guilliland, K. (forthcoming). The Midwifery Partnership Model: ten years on. In S. Pairman & K. Guilliland (Eds). *Midwifery in New Zealand: achieving a women-centred and midwife-led maternity service (working title).* Christchurch: New Zealand College of Midwives.

Papps, E. (1997) *Knowledge, Power and Nursing Education in New Zealand. A Critical Analysis of the Construction of the Nursing Identity.* Unpublished Doctoral Thesis, University of Otago.

Papps, E. & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: a Foucauldian perspective.* Palmerston North: The Dunmore Press Ltd.

Parkin, P. (1995). Nursing the future: a re-examination of the professionalization thesis in light of some recent developments. *Journal of Advanced Nursing, 21,* 561-567.

Perkin, H. (1996). *The third revolution. Professional elites in hte modern world.* London: Routledge.

Pawlson, G. & O'Kane, M. (2002). Professionalism, regulation, and the market: impact on accountability for quality care. *Health Affairs, 21,* (3), 200-207.

Pelvin, B. (1990). Midwifery: the feminist profession. *Proceedings of the New Zealand College of Midwives National Conference,* Dunedin, August.

Phillips, A. & Rakusen, J. (Eds). (1971). *Our bodies ourselves. A health book by and for women. Boston Women's Health Collective British Edition.* Harmondsworth: Penguin Books.

Perkin, H. (1996). *The third revolution.* London: Routledge.

Ramsden, I. (1990) *Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa.* Ministry of Education, Wellington.

Sandall, J. (1997). Midwives' burnout and continuity of care. *British Journal of Midwifery, 5,* (2), 106-111.

Savage, M. & Witz, A. (Eds). (1992). *Gender and bureaucracy.* Oxford: Blackwell Publishers.

Save the Midwives Direct Entry Midwifery Taskforce. 1990. Direct entry to midwifery. *Save the Midwives Newsletter, 23,* May, 12-20.

Skinner, J. (1999). Midwifery partnership: individualism, contracturalism or feminist praxis? *New Zealand College of Midwives Journal, 21,* October,18-20.

Sherwin, S. (1998). A relational approach to autonomy in healthcare. In. S. Sherwin (Ed). *The politics of women's health: exploring agency and autonomy.* Philadelphia, PA: Temple University Press, 19-47.

Strid, J. (1987). Maternity in revolt, *Broadsheet, 153,* pp. 14-17.

Strid, J. 1991. The need for ongoing discussion and debate. *Maternity Action & Save the Midwives Newsletter, 26,* Autumn, p.1.

Sullivan, W. & Benner, P. (2005). Challenges to professionalism: work integrity and the call to renew and strengthen the social contract of the professions. *American Journal of Critical care, 14,* (1), 78-80, 84.

Teijlingen, E. (2005). A critical analysis of hte medical model as used in hte study of pregnancy and childbirth. *Sociological Research Online, 10,* (2), <http://socresonline.org.uk/10/2/trijlingen.html>

Tertiary Education Commission. (2002). *Tertiary Education Strategy 2002 – 2007.* Wellington: Author.

Timmermans, S. & Kolker, E. (2004). Evidence-based medicine and the reconfiguration of medical knowledge. *Journal of Health and Social Behaviour, 45 (extra issue),* 177-193.

.....Tully E. (1999). *Doing professionalism differently: negotiating midwifery autonomy in Aotearoa/New Zealand.* Unpublished doctoral thesis, University of Canterbury, New Zealand.

Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery, 15,* 165-176.

White, J. (1996).

White, J. (1999). Professional doctorates in nursing and midwifery: unwise indulgence or courageous coming of age? *Focus on Health Professional Education: a Multi-Disciplinary Journal, 1,* (1), June, pp. 17 – 27.

White, P. (2004). Medical professionalism and continuing professional development for medical specialists. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 44.* 186 – 190.

White Eyres, J. 1988. Direct entry midwifery: the education of the future. *Save the Midwives Newsletter, 15,* May, 24-26.

Witz, A. (1990). Patriarchy and professions: the gendered politics of occupational closure. *Sociology, 24,* (4), 675 – 690.

Witz, A. (1992). *Professions and patriarchy.* London: Routledge.

Wood, P.J. & Papps, E. (2001) *Safety to practise. Reflections of the Chairpersons of the Nursing Council of New Zealand 1971-2001.* Wellington: Nursing Council of New Zealand.

Working Party on Midwifery, Bridging and Related Issues (1988). *Minutes of meetings from January to June.* Unpublished.

Appendices

Appendix One: statement re. co-authorship

Karen Guilliland
21 Beverly Street
Merivale
Christchurch

30 June 2005

To whom it may concern.

In her doctoral portfolio Sally Pairman has included several pieces of work written in partnership with me. These are:

- Chapter Six: Midwifery Partnership Model: ten years on (Chapter for inclusion in a forthcoming book on the history of the New Zealand College of Midwives. This book is currently being written and edited by Sally Pairman and me and is due for publication in December 2005).
- Chapter Four: The Resurgence of Midwifery (as above)
- Chapter Five: The Evolution of a Professional Organisation (as above)
- Chapter Ten: Midwifery Regulation beyond 1990 (as above)
- Pairman, S. & Guilliland, K. (2001). Midwifery Standards Review: a strategy for credentialling. *New Zealand College of Midwives Journal, 25,* October, 23-28.
- Pairman, S. & Guilliland, K. (2003). Developing a midwife-led maternity service: the New Zealand experience. In M. Kirkham (Ed) *Birth Centres. A social model for maternity care.* London: Books for Midwives Press.

Sally and I have worked closely for many years through our various roles in the New Zealand College of Midwives. Over these years we have developed a way of writing together that truly is in partnership. We sit together and write, both contributing ideas and analysis and challenging each other as together we craft the work. For the portfolio pieces listed above Sally took the first authorship and edited and prepared these particular works for publication.

The first four chapters listed above are chapters of a book that Sally and I are writing and editing together. In writing these chapters, particularly chapters four and five, we drew heavily on historical research undertaken by Sally as part of her professional doctorate.

I have had no other involvement in Sally's professional doctorate.

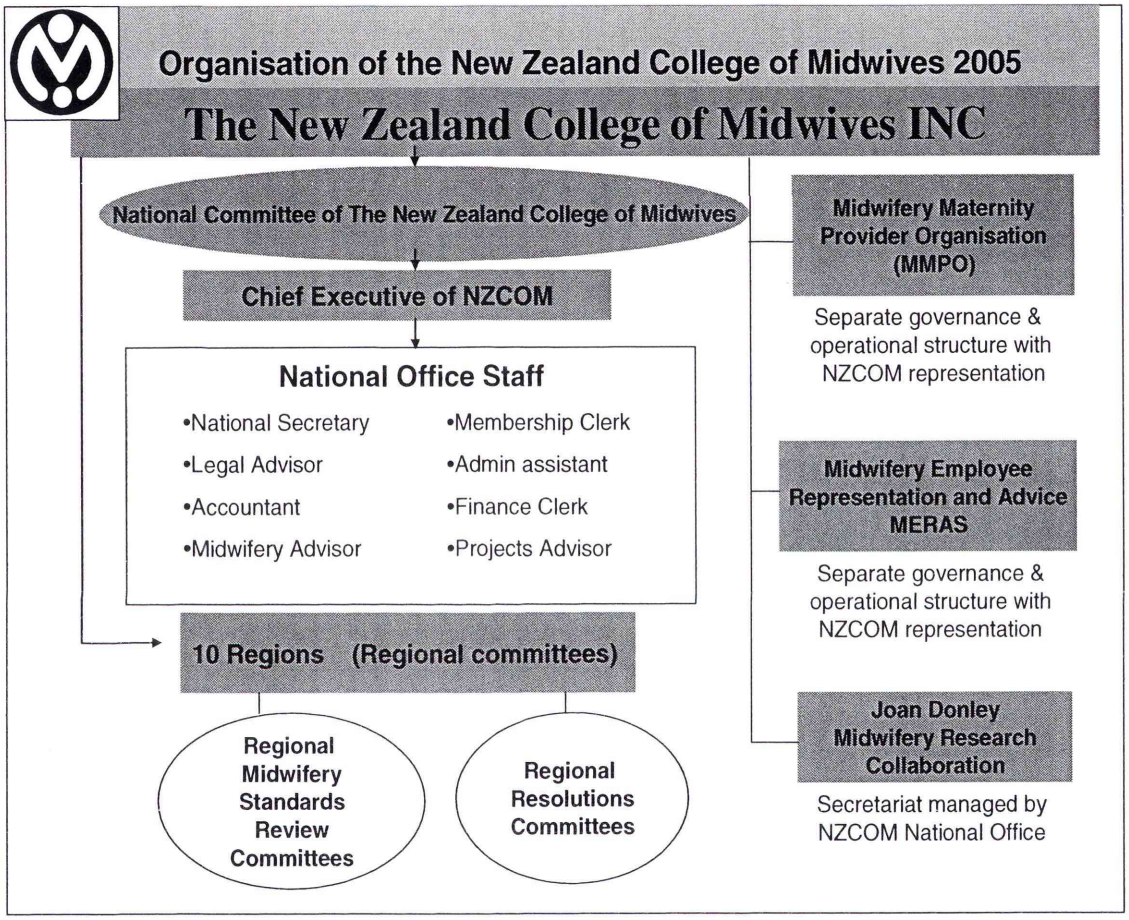
Yours sincerely

RM, MA, MNZM

Production Note:
Signature removed prior to publication.

Karen Guilliland

Appendix Two: Structure of the New Zealand College of Midwives

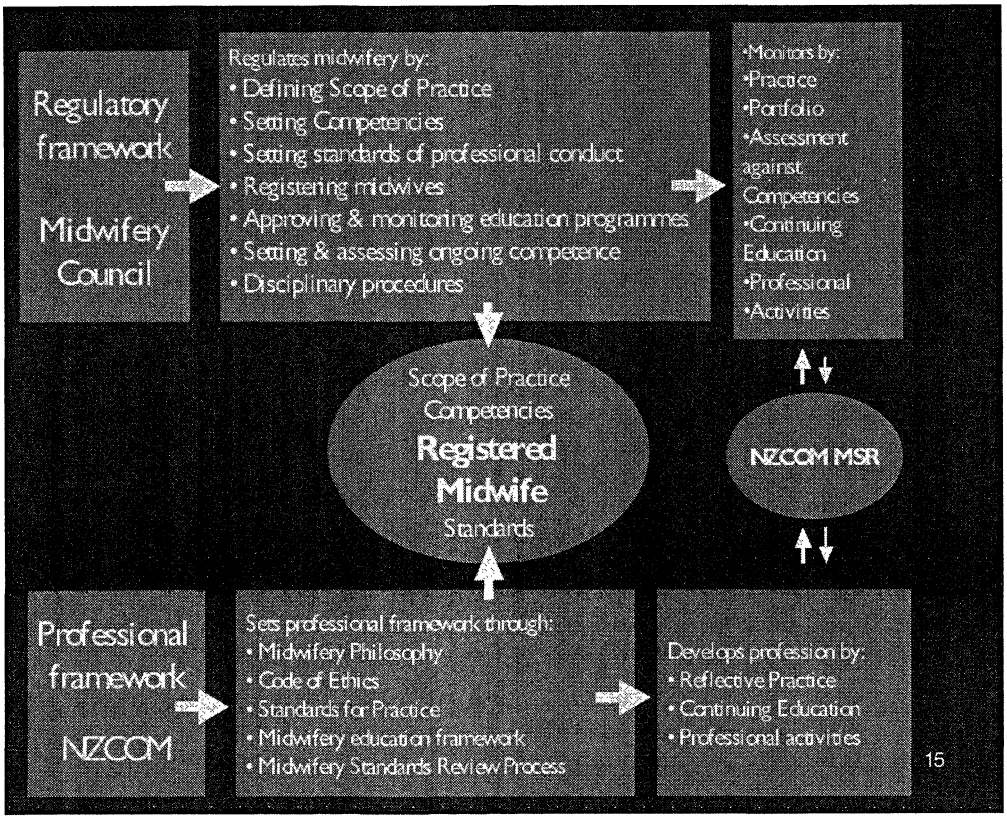


Appendix Three: Role and Functions of NZCOM

Professional practice advice and information: • For all midwives • For District Health Boards (DHBs) • For Ministry of Health/government ministries • For Regulatory Body/other Statutory Authorities • For consumers and consumer organisations • For other professions • For the public	**Professional development/standards:** • For all midwives • Midwives Handbook • Liaison with District Health Boards (DHBs) • Expert witness training • Professional Development Programme • Portfolio Development and support • Section 88 negotiations/interprofessional liaison • Contractual advice and policy development	**Quality Assurance:** • Midwifery Standards Review Process for all midwives • Complaints Resolutions Committees for women • Training programmes
Education: • NZCOM continuing education workshops/programmes • Consensus Statements/practice guidelines • DHB practice workshops • Smoke change workshops • Family Violence workshops • Liaison with Midwifery education providers • Liaison with DHB midwifery educators	**Liaison:** • With consumers • With Maori • With Government/ statutory bodies/ health organisations/non governmental organisations • International midwifery organisations • other professional groups	**Research:** • Secretariat for Joan Donley Midwifery Research Collaboration • Biennial Research Forum

Communication and promotion: • Journal • Midwifery News • Biennial Conference • Publications • Website • Promotional material • Media	**Legal advice and representation:** • Professional Indemnity insurance • legal representation	**Financial management/membership management**

Appendix Four: New Zealand midwifery's professional and regulatory frameworks



Footnotes

[i] *Definition of a midwife*
A midwife is a person who, having been regularly admitted to a midwifery educational programme, 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.

Scope of practice of the midwife
The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the postpartum 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 hte community. The work should involve pre-conceptual and antenatal education and preparation for parenthood and extends to certain areas of women's health, family planning and child care. She may practice in any setting including the home, hospital and community.

World Health Organisation definition of a midwife, as adopted by the International Confederation of Midwives 1972, and International Federation of Gynaecologists and Obstetricians 1973.

[ii] The Midwives Section continued to function as the College structure was developed. In 1989 midwife-members closed the Sections and opened the College regions. The College held its inaugural Annual General Meeting in April 1989. See Part Three of this thesis for further discussion of this process.

[iii] The NZNA was established in 1909 as the New Zealand Trained Nurses Association. Because of the small numbers of nurses and midwives in New Zealand and the geographical difficulties for communication, midwives were encouraged to join the association. In 1935 midwives and maternity nurses set up the Obstetrical Group within NZNA. In 1969 they upgraded this to the Midwives and Obstetrical Nurses Special Interest Section to enable them to join the International Confederation of Midwives. Eventually the name was shortened to the Midwives Section of NZNA.

[iv] Midwifery Scope of Practice (as approved by Midwifery Council 28/7/04)
The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.*

The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.

Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for

pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.

The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides.

[In relation to a preterm baby the Midwifery Council defines the six-week postpartum period as commencing from the expected date of birth rather than the actual date of birth. That is, Council recognises that the postpartum midwifery role for preterm babies may extend beyond six calendar weeks]

Midwifery Council of New Zealand, 2004a.

[v]Revised Competencies for Entry to the Register of Midwives (as approved by Midwifery Council 30/7/04)

Competency One
"The midwife works in partnership with the woman throughout the maternity experience."

Explanation
The word midwife has an inherent meaning of being "with woman". The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early parenthood. The midwifery relationship enhances the health and well-being of the woman, the baby and their family/whanau. The onus is on the midwife to create a functional partnership. The balance of 'power' within the partnership fluctuates but it is always understood that the woman has control over her own experience.

Competency Two
"The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care."

Explanation
The competent midwife integrates knowledge and understanding, personal, professional and clinical skills within a legal and ethical framework. The actions of the midwife are directed towards a safe and satisfying outcome. The midwife utilises midwifery skills that facilitate the physiological processes of childbirth and balances these with the judicious use of intervention when appropriate.

Competency Three
"The midwife promotes practices that enhance the health of the woman and her family/whanau and which encourage their participation in her health care."

Explanation
Midwifery is a primary health service in that it recognises childbirth as significant and normal life event. The midwife is therefore responsible for supporting this process through health promotion, education and information sharing, across all settings.

Competency Four
"The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care."

Explanation
As a member of the midwifery profession the midwife has responsibilities to the profession. The midwife must have the skills to recognise when midwifery practice is safe and satisfactory to the woman and her family/whanau.

Each of the above competencies has a number of criteria that provide detailed measures of how a midwife would demonstrate her competence against each competency statement. The full list of competencies and criteria can be found on the Midwifery Council of New Zealand website (www.midwiferycouncil.org.nz)

Midwifery Council of New Zealand, 2004b