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MIDWIFERY SCOPE OF PRACTICE: AUSTRALIA AND THE INTERNATIONAL CONTEXT

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SUMMARY

This paper provides an overview of the international context of midwifery practice in western industrial societies and compares this to the Australian situation. Reflection on the author's experience of midwifery whilst working in a solo private practice is offered under seven broad themes. These themes include: global trends, culture of childbirth in Australia, midwifery education, midwifery regulation, funding, supportive infrastructure, and personal practice principles and outcomes. Current challenges are identified and strategies suggested to effect change.

Respect For Commonality And Difference

Midwives and Nurse Practitioners share some common issues on which they can collaborate at this point in their respective histories in Australia. There are also, I believe, fundamental differences in the title and scope of practice between the two groups. This is entirely appropriate and it is in the public interest that it be acknowledged and made explicit in the realms of education, policy, regulation, and professional identity. Recent scholarship serves as a powerful reminder that,

“midwifery practice is always a political act,” and further, that
“what we name ourselves and our practice is of critical significance,”
(White 1999; Thompson 1996).

I don't believe this is any less true for nurse practitioners than it is for midwives, more particularly so in the current economic and political climate of privatised corporate health services and a Medicare / public health system that is rapidly haemorrhaging from longstanding neglect and abuse.

The following seven themes encompass issues I have written, spoken, and acted upon in many forums over the past five years, and this paper draws on those resources.

Theme 1: Global Trends / The Legacy Of Language And History

Midwives have an international definition and scope of practice that transcends race, ethnicity, culture and class boundaries. Within this definition, and with endorsement from the World Health Organisation, International Confederation of Midwives, and International Federation of Obstetricians & Gynaecologists a midwife is a person who cares for childbearing women and their families across the continuum of pregnancy, childbirth, and the early postpartum period, in a variety of settings, on her / his own responsibility, referring where appropriate, (WHO, 1996). Two thirds of the worlds' childbearing women are attended by midwives, and the majority of these midwives

are not nurses, (Oakley & Houd 1990). In western industrial societies some of these midwives may hold the dual status of midwife and nurse. It is only in the past 80 –100 years in some western, industrial societies such as Australia that midwifery education, regulation, and service provision has become intertwined with that of the nursing profession, (Summers 1995).

When one practises in accordance with the international definition of the midwife, what is being practised is midwifery, and this is explicitly understood, articulated, educated, and legislated for in many countries around the world, and increasingly in many western industrial countries as women reclaim their procreative and birthing power, Donnellan – Fernandez (1999). Internationally this is becoming defined as the “humanisation of birth movement,” (Robertson 2000).

My intent in educating myself as a midwife was in order to practice midwifery. When I registered as a midwife in South Australia in 1993 I brought with me 9 years experience, socialisation, and postgraduate education as a general and psychiatric nurse. It was as clear to me then as it is now that there were few places within mainstream maternity service provision to practice midwifery according to the international definition of the midwife, despite the funding and rhetoric of the Federal Alternative Birthing Services Program, endorsed by a previous Labour government in 1989 under the Federal Women’s Health Policy, (The New National Agenda For Women 1993). In 1993 organization of maternity services dictated that there were many offers of employment to practice maternity nursing under the title “midwifery.” Given the current and projected shortfall in the number of midwives in Australia, it is not cynical to expect this to continue, despite the implementation of new midwifery models.

Theme 2: Australian Birth Culture

Despite a decade of state, national and international government reports (Rocking The Cradle 1999; NHMRC 1998; NHMRC 1996; Cumberledge 1993, Winterton 1992) calling for major reform to maternity services, and many independent studies demonstrating superior outcomes when women undertake midwifery led care, few women in Australia identify a midwife as their primary caregiver, (Lane 1999). The entrenched effects of a century of institutionalised birthing practice have shaped several generations of public perception (Willis 1989). Many women experiencing normal pregnancy and birth in this country now believe that it is not only desirable, but essential to have a specialist doctor / obstetrician ‘manage’ their pregnancy and birth.

Women have been enculturated with illusions of greater safety, control, and the elimination of pain in childbirth via images projected by those with power to influence the mediums of popular culture, but without any of the responsibilities to advise on the physical, personal and social costs associated with such ‘choices.’ Midwives working within institutionalised settings are identified and perceived as ‘nurse,’ (and therefore implicitly subject to the direction of a doctor), including when they provide most of a woman’s pre or post birth care, or are the principle attendant at a birth.

That woman as a group are still seeking diversity of care options in childbirth has been extensively documented in Australia over the past decade, (NHMRC 1996, Federal Senate Inquiry 1999). Midwives can provide them with viable options that are safe, satisfying and cost effective, if these options are a visible part of mainstream culture. One of midwifery's biggest challenges in the twenty – first century in Australia is a strong public relations exercise; ie: midwifery must promote itself back into the community where it is most usefully located, but has long been forgotten, (Summers 1995, Green 1999). Childbearing and rearing as a social experience also requires reclamation by women's and midwives groups working in partnership to identify common values, goals, and directions, eg: Australian Midwifery Campaign.

Themes 3 & 4: Midwifery Education And Midwifery Regulation

Issues of education and regulation are fundamentally linked. There is a strong global trend in western industrial societies **away** from requiring all midwives to first be educated as nurses, and many countries such as the United Kingdom, Canada, New Zealand, and half the American states have introduced three to four year baccalaureate programs for midwives. Most also legislate for specific midwifery regulation, (Vadeboncoeur 2000, Guilliland 1999, Donnellan – Fernandez 1999, Wagner 1996).

Professional heresy appears to be the new charge against those who question Australian midwifery's present educational and legislative status as 'specialist nursing practice,' (White 1999). Whilst the history of nursing and midwifery in Australia has been inextricably intertwined at cultural, structural, professional and personal levels for both nurses, midwives and the broader public (Donnellan – Fernandez 1996), current resistance to public and professional demand for change has been articulated by organizations such as the Australian Nursing Federation, (Ilfie 2000). The SA Branch of ANF is on record in stating that introduction of Bachelor of Midwifery programs 'is not in the best interest of the nursing profession,' (Gago, 2000). This stance contradicts the findings of Tracy, Barclay & Brodie (2000) based on current analysis of statistics from the Australian Institute of Health & Welfare, which take into consideration national birthrates, educational preparation of midwives, and labourforce requirements.

Whilst there will always be links, redefinition of the terms of the relationship between nursing and midwifery is not only healthy but has already commenced, and will continue to develop at local, national and international levels well into the twenty – first century.

(Donnellan – Fernandez 1996, 65)

When I first registered as a midwife in Australia, it took a further 4 years to achieve adequate theoretical and clinical preparation to successfully apply for accreditation with the Australian College of Midwives Inc. The current reality and need to address adequate educational preparation for midwives in Australia has recently been examined by Leap (1999) and ACMI Victorian Branch (1998). When I received an Independent Midwife accreditation parchment from ACMI National in 1997, it was numbered 88. The assumption could be that there were 88 independently practising midwives (IPM's) at this time in Australia. In reality, the number of practising IPM's is probably four or five times this. The truth is, nobody, including the regulatory authorities have any ideaNor is there an accurate national picture of skill sets

maintained by midwives in institutional settings. This makes labour force planning little more than haphazard guesswork, and therefore a serious concern.

The first principle of professional regulation is that it should be in the public interest, (COAG Committee on Regulatory Reform, Guidelines for the Review of the Professions Under National Competition Policy, 1999). Analysing whose interest is being reflected in current government rhetoric, policy and legislation regarding 'public interest' is a challenging exercise.

Current arrangements to regulate midwives under single register state and territory Nurses Acts are ambiguous. Apart from their inconsistencies (Bogossian 1998), they are simply not keeping pace with contemporary public health care, nor the education and practice realities of midwifery, (AMALG 2000). I note that since moving to a single nursing register, the Tasmanian and Victorian Nursing Boards, and the Queensland Nursing Council have all introduced separate Codes Of Practice For Midwives.

It is an issue of public interest that consumers are well informed of the risk status of various providers. The significance of title protection for midwifery was robustly debated by the SA Parliament during the passage of the Nurses Act 1999 (Hansard: House of Assembly SA 1998). There are significant differences in the skill and competency levels of a Registered Nurse Generalist, an Enrolled Nurse, and a Midwife. Statutory authorities have a responsibility and a legislative mandate to inform and educate the public with respect to title protection, not make it invisible. Policy statements that utilise inclusive 'nursing' terminology defeat the underlying principle of title protection and are therefore contrary to the public interest. Additionally, requiring midwives to self declare their competence as a nurse is a position that is legislatively indefensible with professional midwifery practice or regulation in many other areas of the western world. It is a position that provides no assurance or evidence to the public or professions that rigorous standards or guidelines for practice are being met, nor that any meaningful quality assurance monitoring is occurring. Legislative amendment to enact joint Nurses & Midwives Acts in all states and territories would address this anomaly, (Donnellan – Fernandez, Eastaugh, Glenie 2001).

The assertion that Nurse Practitioner legislation is 'a good thin – edged wedge' (White 1999) is refuted on the basis that the title and skill sets of a 'nurse practitioner' do not equate with the title and skill sets of a 'midwife.' Nurse practitioners practise nursing and midwives should be practising midwifery. That nurse practitioners are legislated to practise nursing is entirely appropriate. That midwives are legislated to practise nursing continues to be one of the fundamental problems with maternity care in Australia today, and this is in turn reflected in levels of medical intervention in childbirth that far exceed the WHO recommendations for best practice, (Federal Senate Inquiry Into Childbirth Procedures 1999).

Theme 5: Funding

At a material and practical level structure dictates the form and accessibility a population has to servicesNational reform to the organization and funding of maternity services is urgently required if real options and sustainable mainstream change is to occur.

(Donnellan – Fernandez, 1996, 64)

Structural ‘gatekeeping’ is the mechanism by which current medical monopoly over childbirthing services is maintained, further aiding and abetting dominant medical hegemony within broader culture. Current mainstream service provision literally, bureaucratically and financially dissects women’s experience and body into discrete and fragmented episodes of ‘care’ typical of western medical systems based on illness models. Midwives and citizens are justified in claiming that present public and private funding mechanisms that do not provide reimbursement for midwifery services privilege medical dominance and comprise anticompetitive behaviour, (NSW Midwives Association 1999, ASIM 1999). Multiple claims to this effect before the Australian Competition and Consumer Commission (ACCC) would challenge the legitimacy of discrimination inherent in current funding arrangements that constitute little more than ‘protectionism’ for medical industry and its affiliated ‘products.’

The current financial barrier is a major disincentive to those wishing to practice midwifery continuity of care in accordance with the internationally defined scope of practice, and also to those women / families wanting to access this model of service. Rather than continuing to prop up an ailing private health insurance industry at the expense of Medicare and public health interests, the federal government needs to introduce a new and separate maternity funding mechanism that is equitable and accessible to all Australian families.

A maternity funding mechanism that enables every woman to choose her lead maternity provider has been implemented in New Zealand via adoption of a transparent, uniform maternity benefits schedule, (Nurses Amendment Act 1990). In the eight years since its introduction 60 % of women in New Zealand now identify a midwife as their lead maternity carer, and 80 % of labouring women know their midwife. Outcomes for maori women & babies have also improved dramatically,(Guilliland 1999, Cleal 2000). Where is the economic prudence, foresight and interests of the state that negatively discriminates citizen equity in accessing the ‘safest, most cost effective care’ recognized by the World Health Organisation. It is obvious that it is not ‘with’ or ‘for’ women, children and families.

The Australian Midwifery Campaign, with wide support of organizations and individuals in all Australian states and territories is calling on the state and federal governments,

“to provide access for all women to choose a midwife as their primary caregiver during pregnancy and birth within the health system (public and private), whether in the community or hospital. The current health system is anticompetitive toward midwives, and restricts the choice of women who seek the services of a known midwife,”

(Maternity Coalition, 2000).

Theme 6: Access To Supportive Infrastructure

Access to supportive infrastructure, which includes essential services as well as professional relationships, is as essential for midwives as it is for nurse practitioners.

Supportive infrastructure includes issues such as funding and appropriate legislative amendment, already discussed. More specifically, it also includes appropriate professional indemnity arrangements and access arrangements (to essential services and equipment such as diagnostic screening, pharmacological substances, hospital admission, and referral to integrated specialist obstetric resources, as necessary). These issues are critical to the success of new models of midwifery service delivery, enabling choice and safety for women as well as utilisation of the full complement of midwifery skills in accordance with the internationally defined scope of practice.

Whilst accessible professional indemnity arrangements for midwives and nurses are now available, they are certainly not subsidised by the state as they are for some in the medical profession.

Documents such as, Review of services offered by midwives (National Health & Medical Research Council 1998), recommendations 1 – 7 recognise that midwifery scope of practice **already** encompasses initiation of routine diagnostic testing, prescribing and referral. In South Australia the Nurse Practitioner Project – NUPRAC (Department of Human Services/SA 1999) uses the **explicit** language of Nurse Practitioners And Midwives throughout its 32 recommendations re prescribing, initiating diagnostic tests, referrals, and gaining clinical and admitting privileges in SA public hospitals. However, in order to legitimise these arrangements, health department guidelines are required, (eg: a midwives formulary), as is amendment to state and federal legislation, eg: Controlled Substances Act 1984, and the Health Insurance Act 1991.

Guidelines For The Granting Of Clinical Privileges And Admitting Privileges For Nurses And Midwives In Public Hospitals In South Australia (Department Of Human Services, SA 1999), move both groups toward greater possibilities for autonomy in accessing established infrastructure. Trends in Australia toward deregulation and the outsourcing of public health contracts herald the potential for innovative, cost effective models of midwifery care, more particularly so if they are lobbied for by the community.

Theme 7: Personal Practice Principles And Outcomes

To date, midwives practising independently in Australia have distinguished themselves from midwives practising as employees of the state, and also from midwives tenured to private service contracts in hospitals, or with other providers. The definitive characteristic of midwives practising independently, has been that the midwife's primary allegiance is to the woman and family who have engaged her in service, not to the state or to any private employment contracts regulated by others. This allegiance is the foundation of a relationship whose boundaries are mediated by cornerstones of responsible self – determination and professional, personalised continuity of midwife carer. The 'relational emancipatory model of midwifery care'

(Donnellan – Fernandez 1993) engages the midwife as a multidimensional facilitator of passage throughout the childbearing continuum. It is acknowledged that this process is dynamic and that the source and potential for transformational reciprocity resides within all who are engaged in the relationship.

I commenced private midwifery practice in 1994, after establishing mentoring and preceptorship arrangements with several Independently Practising Midwives (IPM's) in Adelaide. These IPM's were experienced in providing woman – centred, continuity of midwifery care throughout pregnancy, birth and postnatally. All were accredited to the national standards of the Australian College of Midwives Inc (ACMI) and utilising the full range of their skills. By 1997 I was myself able to accredit with the ACMI, and the same year successfully applied for clinical privileges and admitting rights to two tertiary referral maternity hospitals in Adelaide.

Since 1994 continuity of midwifery care throughout antenatal, intrapartum and postnatal phases has been provided for approximately 130 women and their families. Place of birth has included hospital, birthing centre, and homebirth, with a majority of care provided in people's own homes. Collaboration with obstetric colleagues, other health professionals, and community networks is a regular occurrence to optimise health outcomes for families.

On average I attend two births / month, in addition to ongoing antenatal and postnatal consultations. In terms of caseload practice this is considered the equivalent of .5 FTE, but depending upon needs, outcomes and actual labour and birth times, this can fluctuate. (In the case of a homebirth a second midwife will also attend for support). I appreciate the flexibility of caseload practice as during this period I have supplemented my income in several ways, including midwifery relief work, consultancy, and the facilitation of 'From Pregnancy To Parenting' groups which I coordinate in conjunction with a local yoga centre and naturopath.

Families are contracted with on a private 'fee for service' basis, as there is currently no public health reimbursement / Medicare access to rebate midwifery service in Australia. Some private funds such as Health Partners, NIB, and Defence Health are providing a near full rebate toward the cost of homebirth, but the large providers such as Medibank Private and Mutual Community exclude midwifery from reimbursement status. Current approximate cost of continuity of midwifery care for pregnancy, birth and postnatal visiting is \$ 1500 - \$ 1700 in Adelaide. The 'fee for service' arrangements in private midwifery practice raise important issues of access and equity, creating tensions that I have found ethically confronting at the level of the personal and the professional. Where women and their families have paid for my services over the past six years I estimate that they have saved the public health system over \$ 250 000, a conservative estimate, and far in excess of my own remuneration.

It is often assumed that midwives practising independently only provide care for 'low risk,' affluent middle class families. In my experience the profile of families seeking continuity of midwifery care is rather more diverse. Increasingly I am approached by families with 'special needs,' or those whose pregnancies have been labelled 'high risk' for continuity of midwifery care, as collaborative support to their obstetric care.

A summary of maternal and infant outcomes in 117 families is provided. These outcomes compare favourably with physiological indicators collected by the Pregnancy Outcome Unit of the South Australian Health Commission for 1998.* Satisfaction levels with care throughout antenatal, intrapartum and postpartum phases was high as evidenced by comments returned with 6 week postpartum formal evaluation. These outcomes demonstrate that obstetric intervention and morbidity are significantly reduced where continuity of midwife carer is practiced in conjunction with appropriate referral.

Maternal & Infant Outcomes In 117 Families

Total continuity of midwife care for 111 cases : 86 planned homebirths
25 planned hospital or birth centre
46 % having a first baby

90 % Spontaneous vaginal birth rate (includes 5 home VBACs & 1 birth unit VBAC)
VBAC = vaginal birth after caesarean section

7% Caesarean section rate

3% Assisted vaginal birth rate (1 forcep liftout, 1 ventouse / maternal exhaustion,
1 ventouse/second twin)

30 Waterbirths (3 of these in hospital)

Perineal Outcomes: 64% Intact
15% First Degree Tear
20% Second Degree Tear
1% Episiotomy

Transfer rate from planned homebirth to hospital is 10%

Note: There were 6 antenatal referrals / transfers to specialist obstetric care

These included: # Preeclampsia @ 33weeks
Antepartum haemorrhage @ 37 weeks
Breech presentations x 2 @ 36 weeks
Obstetric cholestasis @ 24 weeks
Fetal supraventricular tachycardia @ 33 weeks

96 % of infants fully breastfeeding at 4 months postpartum

4 cases of postnatal depression within 6 weeks postpartum with psychiatrist involved
0 neonatal or maternal deaths

- Birth outcomes in South Australia 1998: 62% spontaneous vaginal birth rate; 27% induction rate; 23% augmentation rate; 31% epidural rate; 24% caesarean section rate (SAHC Pregnancy Outcome Unit)

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