# A REVIEW OF MIDWIFERY LEGISLATION IN AUSTRALIA – HISTORY, CURRENT STATE & FUTURE DIRECTIONS

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## ABSTRACT

The legislative regulation of midwifery in Australia, as elsewhere, governs the practice of midwives in the profession and controls the entry of new practitioners. Legislation exists in all states of Australia, and since 1992 there have been marked changes in the nature and scope of legislated control. This paper explores the origins of midwifery regulation, the recent changes in legislation and reviews the current Acts, Ordinances & Rules governing midwifery. In doing so, it examines common themes and areas of discrepancy across the country. The implications of both are discussed in terms of present implementation and future development.

## INTRODUCTION

The earliest formal regulation of midwives and their practice in Australia occurred in Tasmania with the introduction of the Midwives Act of 1901. This Act provided the template for other states as they struggled to implement a means to regulate the practice of midwives. Such regulation was deemed a necessary professional response to accusations that midwives were responsible for excessive maternal and infant mortality. By 1926 all states of Australia (excepting the territories: Australian Capital Territory and Northern Territory) had established means to register midwives.

Some sixty years later, midwives remain regulated by state specific legislation, and the recent changes to the legislation and the historical background of regulation form the central focus of this paper. Legislation governing midwifery practice varies from state to state, and a comparative analysis reveals that the historical struggle for professional control over childbirth is a legacy which is still evident in the most recent legislation. Indeed, this legacy may well have significant negative impact on the future development of the profession, and it is therefore timely that an exploration of present legislation form a platform for professional debate across the country.

### The Historical Legacy

The history of midwifery regulation in Australia draws much from the development of regulatory control over midwifery practice which occurred in the United Kingdom. Traditionally, regulation of midwifery practice was market driven. However, in the 13th century guilds of barber-surgeons formed, and they had exclusive rights to use surgical instruments (Baly 1986). It was not their access to instruments which resulted in the barber-surgeons' successful invasion of traditional midwifery practice areas, as the widespread use of forceps was still some 400 years away (Willis 1989). The surgeons were organised into guilds, while midwives plied their trade in isolation from one another, and it was this which determined the strength and profile of each group of practitioners.

By the 17th century, man-midwives established themselves as a political and competitive market place force. This ascendancy was remarkable given the sexual mores of the time, and was contributed to by patronage of the elites which in turn inspired consumer demand. In 1616 a group of midwives in Britain campaigned for a system of instruction and secular regulation (Baly 1986). This was opposed by the highly respected and politically forceful group of general practice physicians, who found that not only could midwifery be lucrative, but it afforded an indirect means to build up the clientele of their individual practices.

General practitioners and man-midwives managed to diffuse subsequent attempts by midwives for professional organisation and education by

attacking their competence and attributing maternal and infant mortality to midwives. Such concern was hollow in view of the fact that the medical profession continued to fail to support any systematic training for midwives (Willis 1989). If midwives were to establish an educational and regulatory base for practice, their competitive power in the childbirth market place would be greater. Thus the professional opposition to midwifery regulation was to continue for 300 years.

In the latter half of the 19th century, the struggle for education and regulation of midwifery gained intensity. Not as one might suppose, primarily out of concern for standards of midwifery practice or high rates of puerperal fever, but rather as a result of a complex mixture of motives, objectives and sectional interests of five distinct reform groups (Dingwall, Rafferty & Webster 1988). These are summarised in Table 1.

In 1902 the Midwives Act was finally passed. The reasons for the length of the struggle, according to Donnison (1977), include the following:-

- opposition from medical groups concerned that midwifery could provide an entry point to general practice
- only a few midwives were educated, vocal, and of sufficient social status to influence the push for registration
- reluctance of midwives to submit to some form of medical control in order to be registered
- opposition of the women's movement who saw the Act as another attempt by men to control women's work
- opposition from nurses seeking their own Act and saw the most appropriate midwife substitute as the general nurse trained as a specialty obstetric nurse.

### The Australian Perspective

In Australia, the issues of nurse training, registration and standardised practice were resolved years ahead of British nursing. However, medical domination over birthing followed much the same pattern as that which had occurred in the UK. Midwives were considered responsible for excessive maternal and infant mortality, rivalry existed in an oversupplied market place, and medical domination was achieved due to lack of midwives, and the fact that midwives were commonly working class women with limited education (McDonnell 1991).

Unlike the UK, where midwifery and nursing were very discrete occupations, in Australia necessity demanded that the two occupations went hand in hand. Furthermore, "Australia adopted the English system of training nurses and midwives, but lacked the strong midwifery leaders to fight for the right of independent midwifery status and practice" (ACMI 1990:17). This meant that subordination of midwifery as a special branch of nursing was largely a foregone conclusion, rather than an area for professional debate. Additionally, while

**Table 1:** ***Interests of Reform Groups in Midwifery Regulations***

| REFORM GROUP | INTEREST |
|---|---|
| The Female Medical Society | to press for the admission of women into the medical profession. |
| Social Reformers | the provision of better maternity care for the poor using a low cost midwife. |
| The Obstetric Society | establishment of a second tier practitioner to relieve them of unprofitable work and thereby bypass the general practitioner. |
| The British Medical Association | represented the interests of general practitioners and saw licensing as a means to control cut price competitors. |
| The British Nursing Association | midwifery was a stalking horse in the campaign to allow the registration of general nurses. |

midwives in the UK have always enjoyed independent practice fights through government policy and legislation, the same protection was not apparent in Australia, as developing medical insurance did not recognise the midwife and historically, the regulation of midwifery practice in Australia has arisen from the efforts of nursing and medicine to control midwifery, the former group being motivated by a zealous need for professional accountability, and the latter group motivated by the need to reduce competition in the birthing market place. "Regulatory bodies were set up in the states and territories of Australia, by nurses and doctors, to regulate the training and practice of nurses and midwives. This was carried out without ensuring that those structures contained the necessary experience to make judgements on midwifery matters..." (Barclay 1995). Table 2 summarises the initial registration of midwives across the country, and is based upon historical accounts (ACMI 1990, Forster 1965, McDonnell 1991, National Midwives Association Australia 1984, Patrick 1987, Sehultz 1991, Selby 1992, Wilson 1992 & Wright 1991).

## Contemporary Developments

Legislation regulating the contemporary practice of midwives varies between Australian States. Comparative analysis of the legislation which governs midwifery practice demonstrates a number of features. Table 3 provides a summary of the Acts, Ordinances, Amendments, and Rules, (referred to collectively in the remainder of this paper as Acts) which regulate midwifery.

Midwives are now governed by nursing regulations in all states of Australia. Barclay (1995) considered that "most states and territories have separate regulations for nurses and midwives." A review of current and indeed the immediate past legislation reveals that this interpretation is not justified in terms of the titles of Acts governing practice. In 1991 Victoria was the *only* state which had legislation specifically referring to midwives in its title, and these Midwives Regulations 1985 were lost to the most recent legislative change in the Nurses Act 1993.

Regulation governing midwifery practice in all states and territories of Australia is subsumed as part of the Acts which govern nursing practice in general. While it may seem petty to discuss the terminology used in the titles of legislation affecting midwifery practice, this does in fact indicate the continuing assumption that midwifery is seen as a category of nursing rather than as a profession in it's own right. This interpretation is supported consistently if one examines the terminology and hierarchical frameworks established in the wording of each of the Acts.

The terminology used to refer to the midwife reflects the underlying assumption that the midwife is first and foremost a nurse. This notion is

**Table 2:** ***Landmarks in Australian Midwifery Regulation***

| States | NSW | VIC | TAS | WA | SA | NT | QLD |
|---|---|---|---|---|---|---|---|
| **Registration of Midwives** | 1926 Nurses Registration Board | 1915 Midwives Act established the Midwives Board<br>1929 Midwifery registration became a function of the Nurses Board | 1901 Midwives Act<br>1902 Registrar of Midwives commenced | 1913 Register of Midwives<br>1944 Nurses Act proclaimed which governed midwifery practive<br>1945 Midwives Registration Board dissolved | 1920 Nurses Registration Act passed<br>1921 Midwives registered under the Nurses Registration Board of South Australia | 1982 Nursing Act provided for the registration of nurses (Midwifery considered a component of nursing) | 1911 Health Act Amendment Act formation of Nurses Registration Board<br>1922 Untrained midwives prohibited from registering |

**Table 3:** ***Summary of Midwifery Legislative Regulation in Australia (1996)***

| | TASMANIA | AUSTRALIAN CAPITAL TERRITORY | VICTORIA | NEW SOUTH WALES | SOUTH AUSTRALIA | WESTERN AUSTRALIA | NORTHERN TERRITORY | QUEENSLAND |
|---|---|---|---|---|---|---|---|---|
| **LEGISLATION REGULATING MIDWIFERY PRACTICE** | Nursing Act 1995<br>Code of Practice (being developed) | Nurses Act 1988<br>Nurses Ordinance 1988<br>Amendments 1994 | Nurses Act 1991 | Nurses Act 1991 | Nurses Act 1984 | Nurses Act 1995<br>Nurses Rules 1993<br>Nurses Code of Practice 1993 | Nursing Act 1992 | Nursing Act 1992 |
| **TERMINOLOGY REFERRING TO MIDWIFE** | "a registered nurse who holds an authorisation to practice midwifery" | "a registered nurse who holds an authorisation to practice midwifery" | Midwife is a registered nurse "person registered under division 1 of the register kept under the Nurses Act 1993" | Midwife "a registered nurse who is authorised by the Board to practice midwifery" | "The prescribed experience for registration as a midwife is experience in each of the following fields of nursing" | "having completed the prescribed course of education and passed the prescribed examination for registration in respect of a branch of nursing as follows.<br>(ii) midwifery" | Midwifery nurse a person whose name appears in the portion of the register for the midwifery category of nursing | "a person who is authorised by the Council to practice midwifery" |
| **PENALTY FOR FALSIFIED REPRESENTATION AS A MIDWIFE (REGISTERED)** | Practice not exceeding 20 penalty units + 2 penalty units daily<br>False claims as above<br>Unauthorised use of title of midwife as above | Practice $2000<br>False Claim<br>Unauthorised use of title of nurse $1000 | (seen as additional nursing qualification)<br>False Claim<br>50 penalty units | False Claim<br>50 penalty units, 12 months imprisonment or both<br>Unauthorised practice<br>50 penalty units, 12 months imprisonment or both | Unqualified practice $1000<br>Unauthorised badge wearing $1000 | Fraudulent claims and representation to register $2500<br>Claiming remuneration/ employment<br>False Claim, Unlawful delegation, Unlawful title $2500 or $5000 for subsequent offences | Acting or practising as a midwife (except in the case of emergency when there is no medical officer or midwife within 20kms)<br>Imprisonment 2 years<br>False claim<br>Imprisonment 2 years | Unauthorised practice<br>20 penalty units<br>False claim<br>20 penalty units |
| **REGULATORY BODY** | Nursing Board of Tasmania | Nurses Board | Nurses Board of Victoria | Nurses Registration Board | Nurses Board of South Australia | Nurses Board of Western Australia | Nurses Board of the Northern Territory | Queensland Nursing Council |
| **MIDWIFERY REPRESENTATION (ON ABOVE)** | no specific requirement for midwifery representation (3 nurses nominated by the Minister, 2 nurses elected by nurses who whole practice certificates) | no specific requirement for midwifery representation however, 4 members elected in accordance with the Health Professions Boards (Procedures and | no specific requirement for midwifery representation however 9 nurses are required 2 of whom are state enrolled nurses | no specific requirement for midwifery representation however 3 nurse (midwives not addressed) members elected in accordance with the regulations + one enrolled nurse or | no requirement for midwife representation on above | one person nominated by the ACMI (WA) who has knowledge of and experience in midwifery and is registred in division 1 of the register | no specific requirement for midwife representation | no specific requirement for a midwife Council member |

reflected in the regulations which restrict midwifery to registered general nurses. While Tasmania, Australian Capital Territory, Victoria, New South Wales and Western Australia require that one must be a registered nurse before being a midwife, this aspect of the legislation is less than clear (according to Barclay 1995) in South Australia and the Northern Territory.

While advice from the Nursing Board of South Australia (Wicker 1996 personal communication) was clear in dismissing the potential or actual direct entry registration of midwives, the Act in itself is somewhat ambiguous, when first considered. South Australian legislation appears to permit the registration of midwives who are not nurses, yet views midwifery as a branch of nursing thus "the prescribed experience for registration as a midwife experience in each of the following fields of nursing" (Section 7 Sub-Section 4). However, it is the enactment of the prescribed qualifications for registration which limit entry. The Act requires a midwifery certificate issued by designated hospitals within South Australia, or interstate, or overseas registration be supplied, as part of application procedures. A similar argument could be applied to the interpretation of legislation from the Northern Territory.

In the Queensland legislation. there is some recognition of the category of registrants who are midwives but not necessarily nurses, in relation to annual licence certificates under Section 74 Sub-section 6: "If a midwife who is not a nurse fails to pay the prescribed fee for an annual licence certificate within the prescribed period, the Council must immediately revoke the midwife's authority to practice midwifery". There is also recognition of single register midwives being recognised under the new Act, but no specific indication as to the status of new single register midwives (Barclay 1995).

The issue of single register midwives is intimately linked with the recognition of direct entry registered midwives from other countries who seek registration within Australia. It would be ironic if midwives from other countries were pertained to register based on a pure midwifery background while we fail to legislate for direct entry practice in our own country. While it is not the intention of this paper to debate the merits of direct entry to practise, when we permit registration of direct entry midwives from overseas this can be interpreted in a number of ways:

- midwifery education outside Australia is superior to any direct entry programmes we could offer
- intensive midwifery dedicated practice and education is valuable only when imported
- non-nurses who wish to practise midwifery in Australia should seek education and qualification in another country and then apply to have this recognised.

If direct entry recognition is to be considered then this will have impact on the terminology used in revision of legislation. Indeed, as the legislation in many states currently stands it will effectively preclude recognition of overseas midwives from direct entry courses, as the midwife is required to be a registered nurse who holds an authorisation to practise midwifery.

Penalties can be imposed for false representation as a registered midwife. These penalties vary from $1000 for unqualified practice in South Australia, for example, to 2 years imprisonment in the Northern Territory. Barclay (1995) identifies that the system of penalty units applied for unregistered practice is only relevant to Tasmania. However, this system is also in place in Victoria, New South Wales and Queensland, and was in 1993 when the author undertook a similar review of the then legislation. The notion of penalty units are not defined in legislation because in practice these alter, and usually indicate some monetary value. For example, according to Fox-Young (1996 personal communication) the current penalty unit in Queensland is somewhere in the region of $60-$70.

In addition to unqualified practice, penalties are also imposed for use of title, wearing of badges, and claiming remuneration. In the Northern Territory, one can practise as a midwife in case of an emergency when there is no medical officer or midwife within 20 kilometres. While this may be an artifact of the dispersed population in the region, a similar argument could also be utilised in other sparsely populated areas. This idiosyncracy also raises another issue, which relates to the competence of medical practitioners

to practise midwifery. There is no requirement for medical practitioners to demonstrate competence in the care of childbearing women, so in fact a traditional birth attendant may be more practised and skilled than a medical officer who falls within a twenty kilometre radius.

In the area of unqualified practice and the use of the title of midwife, the legislation appears to be a somewhat of a toothless tiger. Given that the legislation in all states falls short of defining the practice of midwifery and limits the "midwife" to the ability to be recognised by the registering authority, this creates some cause for concern in relation to enforcement of legislation and control of the profession. An unqualified midwife merely has to refer to herself/himself as a birth advocate or attendant in order to avoid the titular penalty associated with "midwife". Furthermore, as the practice of midwifery is not defined in legislation, how can the legal system find a person who assisted in the care of women during childbirth in violation of undefined practice parameters?

It is, however, worth noting that the penalties imposed for unqualified practice and representation have substantively increased in the most recent changes to legislation. For example, in Western Australia under the Nurses Act 1968-80 and the Nurses Amendment Act 1980, the penalty for falsified representation was $200 or 3 months imprisonment. This has now increased to $2500 or $5000 for subsequent offences under the Nurses Act 1992, which represents an attempt by legislative change to stiffen penalties and deter unqualified practice. Similar changes are evident in those states which have recently updated their legislation.

Perhaps the most important concern for midwifery practice arising from these Acts is that of the regulation of professional conduct. As recently as 1992 midwives in Victoria and Tasmania were unable to practise without the supervision of a medical practitioner, despite the fact that there were no specifications as to the skills required of the supervising medical officer. This was a cause for concern as Ernst (1984) related, that the physicians graduating today are no more prepared to practise midwifery than in the past. This situation demanded and received attention in legislative reviews. Under previous regulations, midwives in Victoria were legally required to have a medical practitioner authorise one of the most basic of midwifery assessment techniques, that of vaginal examination. In the past three years there has been a great deal of revision in legislation which has omitted the archaic (but relatively recent regulations) such as the following:

*The midwifery nurse must be scrupulously clean in every way, including her person, clothing, appliances and premises; she must preserve the skin of her hands, as far as possible, free from cracks and abrasions, and must keep her nails clean and cut short. Whilst attending any patient she must wear a clean dress of washable material, such as linen, cotton, etc, which must be boiled, and the sleeves of which must be made so that they can be tucked up well above the elbows, and over it a clean, washable apron or overall.*
(Nursing Regulations 1980, Australian Capital Territory: section 32).

Despite these changes, there are still some causes for professional concern with regard to the regulation of professional conduct. There are still clauses relating to the requirement for the midwife to be of "good character" (see ACT Nurses Act 1988, Nurses Ordinance, 1988 and Amendments 1994 for example), and while regulations include such judgmental terms we need to be alert as these may potentiate the witch hunt which many feel is occurring against midwives who are independent or in private practice. In the UK it would appear that independent midwives have been conspired against, as Sadler (1988:16) relates "Of the 20 registered independent midwives in the UK, most of whom practice in London, seven have been subject to disciplinary action."

Marsden Wagner (1995) states that the witch hunt "is part of a global struggle for control of maternity services, the key underlying issues being money, power, sex and choice" (p 1020). It involves care providers who do not conform to mainstream practice. Independent midwives formed 70% of his sample of disciplinary hearings.

One way to avoid this would be to ensure that midwives are represented on regulatory bodies. Of all the states and territories only one, Western Australia, specifies in legislation that midwifery representation is required. In the remainder of the country there may be requirement for a nurse

council or board member, but no specific representation of the midwifery profession. In cases of specific disciplinary investigations against midwives, it would be imperative to have midwifery representation, However, the views and interests of the midwifery profession need to be represented in all the functions of such regulatory authorities.

The regulation of professional conduct is being explored by regulatory authorities in a more active and specific way than it was in 1992. Codes of Conduct are currently being developed in, for example, Tasmania (Clark 1996 personal communication), and the first formalisation of these is that of the "Nurses Code of Practice" 1995 in Western Australia which provides for functioning in diverse settings and within level of competence. To date the only profession specific code for midwives has been released by the Nurses Board of Victoria, "Code of Practice for Midwives in Victoria" 1996.

The final issue which requires urgent professional debate is that of mutual recognition and the impact that this has on midwifery regulation. While the Australian Capital Territory legislation is the only one which refers specifically to the Mutual Recognition Act, all states identify that registration (as a result of an educative programme which meets the required standard) in another state would be considered for application for registration within that state. This in sense constitutes mutual recognition, and, although it is not automatic, it is for the most part a formality. Difficulty arises when courses recognised in one state by the registering authority are not recognised by another state's registering authority.

Consider the experience of Australian Catholic University which attempted to implement a common midwifery curriculum across two states. In Victoria, the Nurses Board accredited the proposed curriculum; however, in Queensland, the Queensland Nursing Council when presented with the same curriculum denied accreditation of the course. Given that the regulatory authorities reviewed the same curriculum it would appear that there are different requirements in each of the states. Will a midwife who becomes registered in Victoria as a result of undertaking this course be permitted to register in Queensland, or will this be denied?

Disparate standards could have a significant impact on the notion of mutual recognition, and midwives need to be involved in determining not only the standard of acceptable practice, but also in determining standards and procedures for education and course accreditation. The notion of midwifery subservience in relation to medicine and nursing is evidenced also in the education requirements set down in legislation. For example, in the Northern Territory the prescribed course for midwifery training requires 200 hours of *medical* sciences and related *nursing* care. Diverse requirements for education my be an historical artifact and reflect our regulatory beginnings, but these requirements, standards, and accreditation practices need to be addressed.

## CONCLUSION

This review of the current legislation impacting on midwifery practice has explored the historical development and factors influencing regulation. The historical legacy of the development of midwifery in the United Kingdom and in Australia has resulted in the legislation governing midwifery regulation embedded in a nursing tradition, and the subordination of midwifery to nursing and medicine. Since 1992 there have been substantive and much needed changes made to the legislation across the country. Yet there are many issues arising form the attempt to implement current legislation in the present midwifery climate, including; direct entry, single registration, unqualified practice, medical supervision, defining midwifery practice, regulation of professional conduct, midwifery representation on regulatory bodies, educational accreditation and mutual recognition. This paper is limited to the exploration of these issues in a broad sense and provides a trigger for professional debate which will influence the future direction of legislation governing the midwife, midwifery practice and the profession.

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