# The politics of midwifery in Australia: tensions, debates and opportunities*


## Kerreen Reiger

School of Social Sciences
La Trobe University
Bundoora Australia
Email: k.reiger@latrobe.edu.au



**Abstract:**

*The recent international resurgence of midwifery has involved the profession's seeking to gain greater independence and the lessening of medical dominance. In such a context, issues currently facing Australian midwives are significant. This paper outlines the development of research questions with regard to midwives' professional consciousness, and considers the structural context of maternity services. It then explores changing political consciousness and dilemmas. In particular, the emergence of an autonomous professional identity for midwives as articulated by the Australian College of Midwives Incorporated (ACMI), has not been straightforward. Unevenness of educational preparation and a projected shortage of midwives together with growing frustration at inadequate recognition of midwives' distinctive knowledge and skills all pose challenges to policy moves to encourage a greater midwifery role in maternity care.*



***Key words:*** *birth, maternity care, midwifery, politics, professions.*


### Introduction

In recent years, the profession of midwifery has been going through a profound change as midwives seek to become more autonomous health professionals oriented to providing a distinct model of maternity care for birthing women. In Australia, as elsewhere, this involves a shift away from a medical/scientific framework and hospital-centric practice towards one emphasising holistic care, the valuing of intuitive as well as technical knowledge, a collaborative partnership with women and new forms of work organisation. The re-emergence of midwifery away from medical dominance reflects the influence of the feminist critique of medicalised reproduction within the profession and the efforts of consumers who have lobbied governments for wider options in the management of childbirth. Many studies undertaken in Western nations throughout the past decade have testified to equal and better outcomes measured by rates of mortality and morbidity, levels of intervention and maternal satisfaction when midwives provide the primary care (eg. Tew 1990; Tyson 1991; Biro and Lumley 1991; Centre for Economic Research 1997). Governments have also sought to rationalise health-care expenditures, recommending midwifery care as cost-effective and appropriate for women having normal births (Ministerial Task Force into Obstetrical Services NSW 1989; Health Department Victoria 1990; Department of Health UK, 1993; National Health and Medical Research Council 1996; Australian Senate Inquiry 1999). While Australia still lags behind Canada and New Zealand, health policy has been moving towards support for midwifery care in childbirth.

This paper considers some of the issues emerging as the Australian midwifery profession responds to the wider process of the 'rebirth' of midwifery (Kitzinger 1988; Murphy-Black 1995). I outline the development of my research interests concerning midwives' professional consciousness, and then consider the structural context of maternity services. In a somewhat tentative way, I then explore indications of changing political consciousness and the development of a more autonomous professional identity, especially with regard to the Australian College of Midwives Incorporated (ACMI), and growing awareness of midwives' distinctive knowledge and skills. These developments must be considered in the light of several contextual factors which include international comparisons where midwifery has become institutionalised as providing the most desirable model of care for birthing women, as

well as the local structural context with its particular professional and political struggles. Some Australian research has indicated a significant discrepancy between Australian midwives' claimed sphere of practice, and their 'actual demonstrated practice', in which they remain largely dependent practitioners (Commonwealth Department of Human Services and Health 1996:160). The politics of midwifery also involves industrial and workforce issues, including problems of internal division, as well as obstetric dominance. These in turn implicate educational preparation, which to date has been within nursing and hence has perpetuated continued medical hegemony. How Australian midwives as a total group see their professional role and future is not yet known but is important to explore for both conceptual and practical/ political reasons. This paper reflects my thinking on these issues and forms the basis for research presently underway.

## The birth of my interest in midwifery

For several years I have been studying aspects of the social organisation of childbirth in Australia, from the rise of medicalised birthing under the influence of scientific rationality in the early twentieth century to the attempts of women's community groups to reclaim 'natural birth' from medical power (Reiger 1985; Reiger 2001). Out of this work, I also became an activist with regard to maternity services, starting with participation in lobbying around the Victorian inquiry, the Ministerial Review of Birthing Services in 1988–90. As the organisation which we formed, the Maternity Coalition, developed over subsequent years, we consciously chose a different path to that of groups which designated themselves as 'consumers', clearly demarcating their interests from those of midwives as professional providers. While recognising some inevitable differences of interest and priorities, we sought to draw both mothers and midwives together to seek more 'women-friendly' and less medicalised birthing services. Working politically with midwives, hearing their stories, and frequently their pain at enduring a health system which is oriented to illness rather than to a 'wellness' model of childbearing, has informed my intellectual interest in the professional development and dilemmas of contemporary midwifery.

The complexity of the task, and its international context, was first brought home to me in 1990 when I chaired a difficult meeting of Victorian midwives. They were in turmoil over the recommendation of the Ministerial Review of Birthing Services that the restrictive legislation governing their practice be removed so that they could become autonomous practitioners without the supervision of a doctor. While it took another five years, and much political effort, for this to take effect, in the meantime I became familiar with developments in Canada, and more recently, in New Zealand, in which midwives have been also gaining increasing professional autonomy (Benoit 1989; Bourgeault and Fynes 1997; Guilliland and Pairman 1995; Tully 1999). While in neither case has the role of midwives become as established as it had continued to be in some European countries, and even Britain, major gains have been made in increasing the profile and professional autonomy of midwives, especially in community settings. Although similar political struggles have been underway in the United States (Rothman 1989; Davis-Floyd 1998), many factors are very different there. In particular, the complexity of different state legislative arrangements, the overwhelming dominance of obstetrics and nursing, the privatised health care system are strong barriers to change; yet, on the

other hand, there is greater political organisation of traditional, non-nurse-trained midwives. Understanding contemporary international and local developments requires a longer-term perspective than that of recent decades in which we can speak of a 'rebirth' of midwifery.

## The historical politics of midwifery

Historical analyses reveal how midwives became subordinate to doctors in the late nineteenth and earlier twentieth century, becoming de-skilled into obstetrical nursing as part of the modern gendered division of labour in health care (Donnison 1977; Witz 1992, Ch 4). Under pressure from the predominantly male medical profession, in Australia as elsewhere, restrictive legislation limited the scope of midwifery practice (Willis 1989) and encouraged the hospitalisation of childbirth (Reiger 1985). By the 1950s, the 'specialist-therapeutic' model of birth which privileges obstetricians came to dominate the Australian system (Schofield 1995). Further, midwifery largely became incorporated within the nursing profession, and in Australia it has been a common post-basic qualification often required in the job market but nonetheless undervalued (Barclay 1985; Barclay 1995).

However, since the 1970s, the International Confederation of Midwives (ICM), the International Federation of Gynaecologists and Obstetricians (FIGO) and the World Health Organisation (WHO) have supported the concept, still maintained in parts of Europe, of the midwife as an autonomous health professional. The accepted international definition of a midwife refers to an appropriately qualified practitioner 'able to give the necessary supervision, care and advice to woman during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant'. This emphasis on midwives' professional autonomy has been promoted by the Australian College of Midwives and legitimated on occasions at government level. Midwifery practice, however, remains severely circumscribed by the ideological and economic power of the medical profession, allied with that of nursing and enforced by state regulation which contains midwifery within the ambit of nursing.

## The structural context of Australian maternity care

In view of the historical connections between Australian doctors and the British medical profession, Australia never quite followed the direction of the United States in which the dominance of the profession of obstetrics turned midwives into nothing but obstetric nurses. Nonetheless, by the postwar decades, increasing reliance on forms of technology, including drugs, have become institutionalised in the Australian management of birth as in many other aspects of health care. While examining the organisation of the entire health sector is unnecessary and beyond my scope, several aspects have directly impacted on the delivery of maternity services— funding issues, the legal regulation of midwifery, and, closely related, the social and political power of the obstetric 'specialist-therapeutic' regime (Schofield 1995). While primary responsibility for health care lies with the States, major revenue comes from Federal sources, and an historically shifting mix of funding has supported a publicly funded hospital system at the same time as the ideology and practice of private-fee-for service has reflected the strong political power of the medical profession (Sax 1984; Crichton 1990; Daniel 1990). Until the fraught and flawed development of the Medibank, then Medicare, compulsory health

insurance schemes in the 1970s and 1980s, publicly funded services were deemed to be only for those who could not afford private care.

The management of childbirth has been intricately related to the organisation of this dual system, for, unlike New Zealand, birth in Australia was never considered automatically deserving of public financial support, regardless of the setting, home, small or large hospital, in which it took place. Australian funding arrangements have been closely tied to hospitals, especially the demands of large metropolitan tertiary centres. Community-based services and public health remain very much the poor relation. Birth, already taken from small 'cottage' homes run by midwives with varying degrees of expertise and training, moved from the ambit of the local general practitioner to that of the obstetric profession during the 1960s and 1970s. Schofield argues convincingly, on the basis of NSW evidence but which is likely to have relevance elsewhere, that this development was intricately associated with the growth of private health insurance which underpinned obstetricians' practice financially, and government policy. The latter accepted the profession's argument that it carried the specialist, technical knowledge essential to the management of all births, the physiologically normal as well as those with complications (Schofield 1995). Women increasingly came to believe this too, but the structures of health financing were, and remain, critical with health insurance status a major indicator of the likelihood of medical intervention in birth (Roberts et al 2000).

Providing the larger structural context of course is the expansion of large companies promoting drugs and technology, the political economy of which has been analysed by others (eg Doyal 1979; Relman 1980; Navarro 1982; Davis and George 1993) Although it has not been fully examined in relation to its impact on childbirth, it is of international significance in terms of the waste of resources on inappropriate technologies in developing countries (WHO 1985, Wagner 1994). Closer to home, in my own research, obstetricians indicated in interviews that they saw the great advances of the post-war decades overwhelmingly as technical advances. These were, they said, firstly in terms of antibiotics to control infection, but also the development of fine plastic tubing and needles which enabled the administration of other newly developed drugs, including synthetic oxytocics to induce or augment labour, and epidural anaesthesia (Reiger 2001). The technologies went hand in hand with increased confidence that medical intervention in birth was the major factor responsible for lowering maternal and child mortality and morbidity rates. Anyone who disputes the 'safety' model as defined by obstetricians is deemed uninformed and even dangerous (Reiger 1999).

State policy supported the further medicalisation of birth through technological means, accepting the claims of doctors who moved towards the 'active', that is, technologically assisted, management of labour at an increasing rate by the 1970s. This technical dominance brought with it increased institutional and interpersonal power, especially over midwives who had already been brought firmly under medical dominance by the 1950s. Nonetheless, in Australia, the relative strength of the public hospital system, certainly compared with that in the United States, meant that midwives continued to attend many births as relatively independent practitioners, albeit within the constraints of medical power in the hospital. Both nurse training and the additional year's

midwifery certificate exposed many to an alternative hierarchy with its own authoritarian structures, but also its own culture. Older midwives have described to me how as students within this system in the 1950s-1960s, they were strongly encouraged to try for a vaginal birth, and to 'stretch the perineum out nicely' so as to avoid calling in medical staff! Although the States varied in terms of specific regulations pertaining to midwifery, and even the educational requirements, similarities in practice seem to have been facilitated by the movement of midwives across states, both for training and work opportunities (Peters 1995). In recent decades, the move to university education has undercut hospitals' reliance on student labour, but quite possibly also undermined the separate authority structure which midwifery had traditionally been positioned within, albeit within a nursing framework.

What is the relevance of these background factors to current developments in the 'politics of midwifery'? On the one hand, the swing by all Australian governments, to varying extents during the 1990s, to embrace neoliberal principles of cutting back state-provided services and supporting the private sector has led to new models of health funding such as casemix and to managerialist approaches to health administration. On the other, trying to curtail spiralling health expenditures has opened some new opportunities for innovation in models of maternity care. These have been able to build upon federally funded Alternative Birthing Services programs, associated with the National Women's Health policy. Community Midwifery programs, some of which have included the option of homebirth and team and caseload midwifery models of care within hospitals, have widened the range of alternatives emerging during the 1990s. Leaving aside childbearing women's expressed wishes for greater information, choice and participation in decision-making (Health Department Victoria 1990), how has the midwifery profession itself been responding to the changing structural context and professional developments internationally and in Australia?

## The political organisation of midwives

As the profession has become more vocal about its role as primary caregivers for birthing women, and has advocated the concept of women-centred care and the practice of a 'partnership' model (Guilliland and Pairman 1995), midwives themselves remain divided. In Australia as in Canada, though less so in New Zealand, most remain concentrated in hospitals with the nursing profession controlling their registration and dominating their education, opportunities to practice and political voice (Barclay 1995), They are further divided by internal work practices into antenatal, labour and postnatal care and anecdotal evidence suggests many prefer to stay on traditional roster systems rather than move towards caseload forms of practice which provide greater continuity of care for women. A small group of influential midwives practise in birth centres and a still smaller group which includes non-nurse, or 'lay' midwives, some of whom have overseas training, work in community settings and at home. As is the case overseas, midwifery opinion in Australia reveals divisions also between those following a potentially elitist, professionalising route within the mainstream health system and those committed to a feminist, non-bureaucratic, egalitarian model of 'partnership' with women (Sandall 1995; Lecky-Thompson 1995; personal observation and communication from midwives). There have been suggestions that where midwifery has made significant gains in terms of

integration within the health system, it may be at the expense of its 'woman-centred' philosophy (Bourgeault 1995; Tully 1999).

In recent decades midwives in North America, Britain, Australia and New Zealand have used professional organisations in a political struggle to regain the right to autonomous practice and the training and resources to do so (Kitzinger 1988; Guilliland and Pairman 1995; Lecky-Thompson 1996). The rival claims of obstetrics and nursing make a difficult environment for a political consciousness in midwifery, especially in view of nursing's own professionalising project and these internal divisions within midwifery. Tensions have surfaced in Australian government reviews of maternity services as well as in Nurses' Registration Board hearings of charges against independent midwives for professional malpractice (Lecky-Thompson 1996). The political organisation of midwifery is inseparable from attempts to enhance its professional and community standing.

In Australia, the Australian College of Midwives Incorporated (ACMI) was formed in 1987 from an earlier National Association of Midwives, established in 1978. Interestingly, the initiative for any national organisation reflected the renewal of midwifery associated with the International Confederation of Midwives. When Australia was nominated to join the organisation, Australian midwives attending a 1975 ICM meeting in Lausanne, Switzerland were caught unawares (Peters 1995; Interviews, Reiger ACMI project). Moves in several states to break away from nursing produced state Midwives' Associations, then a national body with state branches. This was given considerable impetus when the ICM conference was held in Sydney, producing a flurry of activity and networking. In spite of its achievements, it appears that the Australian College of Midwives has not yet achieved the cohesion and public profile of similar organisations elsewhere. Instances of inadequate communication with branch members, conflict within the Executive and poor organisational processes are widely reported. Some independently practising midwives have formed their own professional associations and many qualified midwives continue to rely on the Australian Nursing Federation (ANF) to represent their interests. It seems, as Barclay and Jones (1996:129) have noted, that midwives may be lacking in 'political acuity and strength'. While many midwifery leaders, particularly in educational fields, argue strongly for increased autonomy and 'woman-centred' practice, the response of their colleagues to political activism, including that from an explicitly feminist base, is less clear.

In international research on the specifically political aspects of midwifery's professionalising project, questions of the regulation of lay midwifery are often the focus, especially in North America (eg. Bourgeault and Fynes 1996; Davis-Floyd 1998). This is not a significant factor in Australian debates, although general accreditation processes have been contentious. Some detailed work in Canada (Benoit 1989; Bourgeault 1995) and more recently in New Zealand (Tully 1999, Daellenbach 1999) provides insight into the promotion of the professional claims of midwifery and the emerging tensions around them. These take the form of controversies over educational preparation, especially 'direct entry' or non-nursing courses, the role of consumers in maternity service policy formulation and their monitoring of midwifery practice, and about clinical competence, appropriate knowledge and skills and workforce

arrangements.

## Educational developments

Many of the dilemmas faced by the profession at the present time are related to questions of midwives' educational background and especially their complex relationship with nursing. As noted, in Australia most midwives are first trained as general nurses, and they mostly therefore acquire a dual professional identity. Preference for a nursing background reflects both the dominance of medicine and the realities of staffing workplaces, especially in rural areas, but attempts to use nurses for midwifery work remain highly contentious. While most nurses do not need or use their further qualification in midwifery, many midwives are not being employed to advantage and find this frustrating (Commonwealth Department of Health and Human Services 1996). While the Australian Midwifery Action Project is still collating data on current educational provision, it is already abundantly clear that there is little consistency in the educational preparation of midwives. Furthermore, programs in some states have been closed down, and the impact of federal education policy is increasing the cost of post-basic qualifications, in spite of the clear evidence of a worsening shortage of midwives (Tracy et al 2000)

One of the most significant developments has been the emergence in recent years of serious attempts to introduce non-nursing courses, or 'direct-entry' programs. The politics of this development remains somewhat fraught (eg. Australian College of Midwives, Victorian Branch 1999). Preference for the name 'Bachelor of Midwifery' reflects a stress on providing a distinct educational program which would offer a strong health and social sciences basis but avoid the illness framework and socialisation into the medical model characteristic of traditional nursing courses. Although universities in both New Zealand and Canada have now introduced such bachelor degrees, and over half of British midwives are now graduating from them, there is also significant opposition. Some claim that nursing has already moved away from its illness focus anyway and the breadth of skills needed for flexibility in the workforce, especially in rural areas, requires nursing as well as midwifery qualifications. However, an Australia-wide curriculum is in the process of being developed by a Task Force supported by ACMI, to be introduced across several universities from 2002. Although many midwives who want change, and aspiring midwives, have been pinning hopes on this development, some are already expressing disillusionment and frustration at the institutional politics and limitations (Personal communication, February 2001). This is likely to accord with aspects of Canadian experience in which considerable conflict accompanied the development of new programs. For some licensed midwives, these risk lowering clinical standards and some traditional midwives and consumers have been dissatisfied with the perceived 'academic' nature of the new degree qualification for it is seen as threatening the tradition of community midwifery (Bourgeault 1995).

## The role of consumer participation

Organised groups of maternity service users have strongly supported various 'direct entry' programs, and been influential in pushing for new models of maternity care, particularly those in which midwives play a greater role. In Australia, however, unlike New Zealand where midwifery's professional autonomy has increased markedly during the 1990s, continuing controversy bedevils the question of how much

consumers should influence professional developments, especially through a formal role within ACMI. In New Zealand, the College of Midwives achieved major political gains in the early 1990s largely as a result of consumer pressure, and as some activists there have pointed out to me, the NZ College thus owes them a debt. Their right to full membership in the College and significant participation in decision-making and monitoring of professional standards rests on a shared political past in which the philosophical notions of partnership emerged. In Australia, however, the state-based associations and the Australian College of Midwives started without consumer involvement, mostly oriented to distancing themselves from nursing. Nonetheless, as founding College president Margaret Peters noted in an early address, increased midwifery consciousness was itself a response to women's activism in seeking changes in the management of childbirth during the 1970s (Peters 1995; see also Reiger, 2001,Ch 9).

Debates over whether or not consumers should be able to be full or associate members of the College are still lively but unresolved, with quite polarised opinions evident. While those opposed to consumer involvement in what is, after all, a professional association, seem now less likely to say so publicly, on the on-line discussion list 'OzMidwifery' there have been many recent expressions of support for this as a sign of genuine collaboration. The argument that change can only happen if midwives and mothers work collectively, and largely have shared interests, is also basic to a campaign initiated in Victoria in late 1999 to gain government funding for a primary midwife carer for all birthing women. There are other ways in which consumer involvement in maternity service policy development impacts on the politics of midwifery. Articulate community groups are lobbying for legislative change, such as the Australian Midwifery Action Lobby Group (AMALG) in South Australia. Alternative forms of professional practice have also been established within the homebirth movement. In the Home Midwifery program in Queensland in particular, a strong network surrounds the homebirth midwives who are clearly accountable to their birthing community. To sum up, then, the dilemmas of balancing an increasing professional consciousness among midwives with effective partnerships with women as clients and collectively as users of maternity services have emerged in Australia as elsewhere, and are by no means resolved. They are further complicated by workforce-related issues.

### Midwives' clinical skills and workforce participation

An increasing shortage of midwives is readily apparent despite difficulties of assembling adequate data (Tracy et al 2001). National estimates need to distinguish between the many nurses who have a midwifery qualification, but are not using it at all or partially, and those practising to the full extent of their profession. Tracy et al's (2000) calculations suggest some 9-10,000 currently practising midwives, but indicate a looming shortage with less than two-thirds the required replacement numbers currently in educational programs. Asserting a distinctive midwifery role requires establishing distance from nursing, with personal and organisational consequences. An earlier study of midwives in Australia which focussed on the unique characteristics of midwifery care (Barclay 1985), showed that midwives who sought greater autonomy in the workplace experienced role

conflict and professional dissatisfaction which led to significant loss of midwives from the profession. This conclusion has been affirmed more recently through studies by the Commonwealth Department of Health (1996) and Lane (1997). Further, as midwives have received tertiary education in recent decades they are being exposed to a much wider range of disciplines and research paradigms than their medical colleagues or peers who trained earlier, with implications for collegial interaction. There is little sign, however, that medical education is taking any account of the changes in midwifery, and articulate midwives are reporting considerable frustration at obstetricians' obstructing their practice of women-centred care. Furthermore, internal divisions within the profession, and concerns about resistance from colleagues who wish to remain within a nursing-oriented, medicalised model are not uncommon (eg OzMidwifery, March 2001).

At the same time, however, new opportunities are opening up. Midwives working in community settings, in educational institutions and in some progressive hospital contexts, report the development of distinctive midwifery knowledge and clinical practice facilitated by new models of care (eg Hunter et al 1997; Rowley et al 1995). These and other reports raise several questions — how a 'new-style' professional self is constructed and negotiated by midwives in educational and workplace settings; the relationship between professional identity and political commitment; the degree to which midwives feel adequately prepared to fulfil their role as defined by the ACMI and other international midwifery associations; and the extent to which Australian midwives themselves wish to transform their practice from obstetric assistant to autonomous primary carer. Those espousing the latter objective argue that their knowledge bases are different from obstetric models because their practice is qualitatively different from obstetric practice (Lane 1997). While recognising the value of usual empirical information in clinical decision-making, such as pulse rate and blood pressure readings, and also of complex monitoring technologies to assess risk and progress when appropriate, some claim that much everyday work is 'instinctive' or 'intuitive'.

Attention has been given to the nature of instinctive knowledge in nursing (eg. Benner and Tanner 1987; Cioffi 1997; King and Appleton 1997). Cioffi (1997) has also described the underlying component processes making up midwifery intuition. However, only Daviss' (1997) study of midwifery practice amongst the Inuit of Northern Canada has examined midwifery intuition in relation to other forms of knowledge (political, cultural, clinical and scientific). Especially in view of feminist analysis of women's 'ways of knowing' (Belenky et al 1987), Lane's findings from preliminary interviews with twenty Australian midwives indicating the pivotal role of 'intuition' (Lane 1997) are of some significance. These midwives reported close evaluation of the mother's health status according to the usual medical criteria but also, distinctively, by the mother's social relations and emotional status. For them, the skills of the midwife were primarily those of observation, listening, empathy and respect for the knowledge of the woman about herself and her baby. These were used in conjunction with the medical and empirical knowledge. Central to the politics of contemporary midwifery, therefore, are struggles over definitions of knowledge as well as over resources within the health system.

## Conclusion

Many complex issues are intertwined, therefore, in midwifery's journey from medical handmaiden to autonomous primary carer of childbearing women. It would be premature to offer any assessment of developments, other than to recognise the contradictions and challenges. At present we cannot even know how many Australian women would, if they had sufficient information, prefer midwives as primary carers, although levels of satisfaction with midwifery care indicate that there could be a significant groundswell of consumer support (Zadoroznyj 2000). This would have to contend with the established medicalised culture of birthing, and with the reticence of many midwives, again how many remains unknown, to take on the newly defined professional role. The structural context of health care and the role of the state may be the factors which precipitate change. In view of escalating costs, low-technology birthing may yet prove an attractive proposition to health service managers. The danger remains that without commitment to adequate resourcing according to women's differing needs, that is to a model in which funding would be tied to clients rather than institutions, maternity care may be increasingly moved back into the home, but under-supported by professional expertise and over-reliant on women's unpaid caring work. Maternity politics is indeed a tricky business.

## Notes

* This is a revised and adapted version of a workshop address given at the Health Sociology Day at the Australia Sociology Association (TASA) conference meeting in December, 2000. It must be seen as an indication of work currently in progress, and draws in particular on dialogue with my colleague, Karen Lane from Deakin University. Aspects are drawn from research on the Australian College of Midwives, material linked to the Australian Midwifery Action Project which is funded presently by an Australian Research Council-SPIRT grant. The financial support of La Trobe University Faculty of Humanities and Social Sciences is also acknowledged.

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