ADDRESSING THE BARRIERS TO MIDWIFERY - AUSTRALIAN MIDWIVES SPEAKING OUT

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ABSTRACT

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

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

INTRODUCTION

This study as part of a larger project[1] explores and reports the views of midwives from across Australia in identifying the barriers to midwifery within mainstream maternity service provision.

CONTEXT AND LITERATURE REVIEW

In Australia, there are approximately 250,000 live births annually (Nassar and Sullivan, 2001). The majority of these births take place in hospitals staffed by approximately 13,800 registered midwives and nurses working in midwifery (AIHW, 2002), with medical care available either 'on call' or 'on site'. High standards of maternity care are based on the assumption that there is, and will be, the availability of qualified midwives for all women during labour, birth and the postnatal period. Whilst there are clearly areas requiring significant improvement, particularly with regard to Indigenous perinatal outcomes, childbirth in Australia is considered relatively safe compared to international standards, with a fetal death rate of 6.7 per 1,000 live births (Nassar and Sullivan, 2001).

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

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

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

2. What are the strategies to overcome these barriers?

[1] The Australian Midwifery Action Project (AMAP) was funded by the Australian Commonwealth Government through the Australian Research Council as part of the then 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia. This included workforce, regulation, education, and practice and service delivery issues across the country.

METHOD

Sample and data collection

Multiple data collection methods were used over a two-year period. Interactive forums with groups of midwives participating in 28 separate professional conferences and seminars as well as the use of 'graffiti[2] boards, anonymous surveys or 'graffiti' sheets (sample 'graffiti sheet' survey is available on request from the author) placed in professional journals (Table 1) and on a website, were all utilised. Five hundred and sixty three responses were received, with three hundred and ninety six respondents (73.3%) stating that they were registered midwives in current practice. Geographic spread of respondents was extensive with sixty-eight responses (28.8%) from participants with postcodes identified as coming from either remote or rural regions.

TABLE 1

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

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

Data analysis

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

RESULTS

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

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

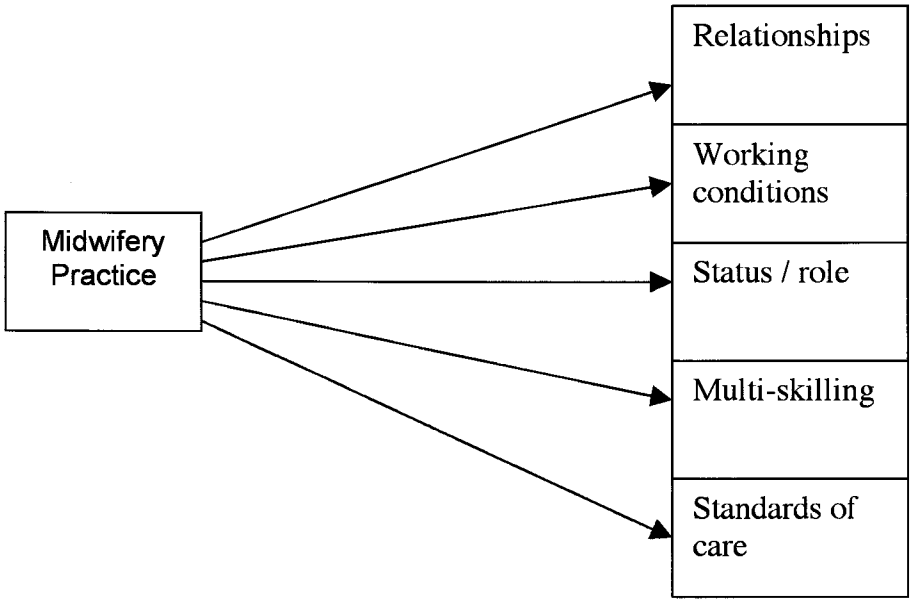

Figure 1: Coding of the relationship of the 'midwifery practice' 'parent' node to related 'child' nodes

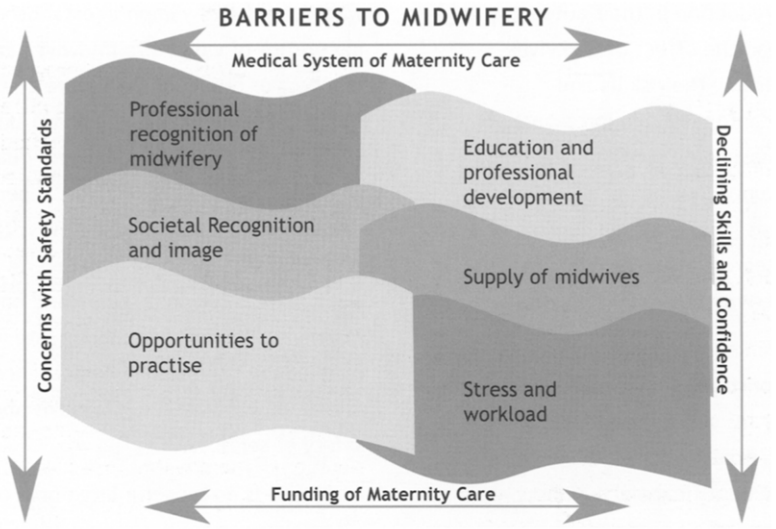

Figure 2. Complexity of barriers to Australian midwifery

KEY THEMES EMERGING FROM THE ANALYSIS

Professional recognition

Reports of lack of professional recognition of midwifery and the role of the midwife came equally strongly from midwives in urban and rural settings. The philosophy of care, whether the workplace culture was medically focussed or woman-centred[3], played a part. Models of medically dominated practice were not the exclusive domain of medical practitioners, with reports that some midwives and unit managers also supported a 'medical' approach to care. For some, this was perceived to occur because of a lack of recognition of the benefits of midwifery and the high level of nursing and medical dominance of midwifery practice that restricted midwives' desire to fulfil their role.

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

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

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

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

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

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

Opportunities to practise

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

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

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

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

Societal recognition and image

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

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

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

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

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

Supply of midwives

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

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

Stress and workload

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

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

The 'system' of maternity care

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

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

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

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

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

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

> 'The medicalisation of childbirth and the reality/ perception that consumers are becoming more litigious are the big blockers for midwifery. I now lack the confidence which I used to have and I know this leads me to do more (often unnecessary) interventions which can contribute to increased morbidity. I just cant fight it anymore" (NLR 17)

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

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

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

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

Midwifery Education

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

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

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

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

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

and appropriate care. Respondents in rural areas also reported difficulty in accessing relevant educational updates and reported being 'fearful' and 'uncertain' and less likely to be able to challenge poor practice and out of date policy.

> 'Lack of education for midwives who re-enter the workforce after extended breaks is a big problem. Midwives who have lost the confidence to work in birth suite / labour ward need proper support and education to regain those skills. There are major professional and workforce issues". (CA 7)

Rural and remote area midwives had particular concerns related to geographical isolation and lack of opportunity to access education because of limited access to funded support.

> 'Provide funding for midwives to maintain their skills by having exchange agreements with metro hospitals for rural midwives to be seconded to update their skills in the common aspects of midwifery, including emergencies". (NSR 16).

DISCUSSION

This study was designed to give a voice to a cross section of midwives who are currently practising and thus arguably, are in the best position to identify, through experience, the existing barriers to their role and practice. The participants have highlighted the need for review and a reorganisation of midwifery services in mainstream maternity care. Their responses indicate that Australian midwifery is in crisis. This relates to significant workforce shortages, problems of quality of educational preparation, serious concerns with workload, quality of care and safety, and access to ongoing professional development and support. A picture of a midwifery workforce that is under-resourced, depleted in numbers and skill mix and that is under-recognised as a profession has emerged, which has serious implications for service providers, policy makers and the profession itself. These findings further substantiate concerns raised in recent Australian research regarding both the midwifery workforce (Tracy et al. 2000) and the obstetric workforce (AMWAC, 1998) and standards of midwifery education (Leap and Barclay, 2002) and regulation (Brodie and Barclay, 2001).

Considerable research has examined the experiences of midwives involved in 'midwifery led' models of care (Green et al. 1998; Sandall, 1997; Brodie, 1996; Stevens and McCourt, 2002) or in the reorganisation of traditional services (Sikorski et al. 1995). In the United Kingdom (UK), several authors have explored the potential impact of health service policy change and reform on the future role of the midwife (Bennett et al. 2001; Lavender et al. 2001). Whilst welcoming changes that may improve services to women, midwives in one study highlighted concerns about additional workload and the need for ongoing education to enable them to adapt to the proposed new roles (Pope and et al, 1996). Australian research has revealed wide-ranging and differing views of midwives' self perceptions of their professional identity and views of childbirth (Lane, 2002).

A recently released report commissioned to determine why midwives leave the profession in the UK has highlighted increasing stress levels, insufficient staffing, and lack of effective leadership and support as some of the key issues contributing to attrition rates (Ball et al. 2002). These UK findings are reinforced by the voices of their counterparts in Australia.

Midwives in this study demonstrated a clear understanding of the challenges facing service planners and managers with surprisingly few participants recommending financial incentives for midwives as a solution. In particular, midwives expressed concerns with the current organisation and funding arrangements for maternity care which were seen to benefit medical practitioners, and restrict women's choices. Many identified direct funding of midwifery care within a broader public health approach as a key strategy to address these structural barriers.

Within this context, midwifery autonomy is not recognised or supported and this could be contributing to lack of job satisfaction and increasing attrition from the midwifery workforce as found in Britain (Stafford, 2001; Ball et al. 2002). Coupled with an 'organisational cultural norm' of high-tech medical management (Mason, 2001) and escalating levels of medical intervention (Roberts et al. 1999), the role of the midwife in Australia was seen by participants as being dominated by medicine (Willis, 1983) and controlled by nursing (Barclay, 1985; Summers, 1998). This is further exacerbated by a perception that the medical profession controls management decisions and resources. Such 'occupational imperialism' (Larkin, 1983) further subordinates midwifery by ensuring strategic control of maternity services and denying the rights of consumers to access midwifery care.

Within this organisational culture, many midwives are unable to fulfil the role for which they were educated and are losing their skills and confidence. Inappropriate use of enrolled and registered nurses and shortages of qualified midwives has a cumulative

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

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

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

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

CONCLUSION

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

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

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

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

Author's note

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

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REFERENCES

AIHW (2002) *Nursing Labour Force 1999.* Australia: Australian Institute of Health and Welfare.

AMWAC (1998) *The Obstetrics and Gynaecology Workforce in Australia; Supply and requirements 1997-2008.* Commonwealth Government Printer.

Australian College of Midwives Inc. (2002) ACMI (Draft) *Standards for the Accreditation of 3 year Bachelor of Midwifery Programs.* Melbourne: Australian College of Midwives Inc.

Ball, L., Curtis, P. and Kirkham, M. (2002) *Why do midwives leave?* Sheffield: Women's Informed Childbearing and Health Research Group, University of Sheffield.

Barclay, L. (1985) How is the midwife's training and practice defined in policies and regulations today? *Health Policy* 5, 111-132.

Bennett, N., Blundell, J., Malpass, L. and Lavender, T. (2001) Midwives' views on redefining midwifery 2: Public health. *British Journal of Midwifery* 9, 743-746.

Bogossian, F. (1998) A review of midwifery legislation in Australia - History, current state and future directions. *Australian College of Midwives Journal* 11, 24-31.

Brodie, P. (1996) *Being with women: the experiences of Australian team midwives.* Masters Thesis. Sydney: University of Technology, Sydney.

Brodie, P. and Barclay, L. (2001) Contemporary issues in Australian midwifery regulation. *Australian Health Review* 24, 103-118.

Campbell, R. and Macfarlane, A. (1994) *Where to be born? The debate and the evidence,* Second Ed. National Perinatal Epidemiology Unit.

Commonwealth of Australia (2001) *Consumer Participation in Accreditation Project Report,* Commonwealth Department of Health and Aged Care.

Flint, C., Poulengeris, P. and Grant, A. (1989) The 'Know Your Midwife' scheme - a randomised trial of continuity of care by a team of midwives. *Midwifery* 5, 11-16.

Grant, J.M. (2000) Editor's choice. *British Journal of Obstetrics and Gynaecology* 108, 5-6.

Green, J.M., Curtis, P., Price, H. and Renfrew, M.J. (1998) *Continuing to care: The organisation of midwifery services in the UK.* Hale: Books for Midwives Press.

Harvey, S., Jarrell, J., Brant, R., Stainton, C. and Rach, D. (1996) A randomised, controlled trial of nurse-midwifery care. *Birth: Issues in Perinatal Care and Education* 23, 128-135.

Health Department of Western Australia (2001) *Enhanced Role Midwife Project,* Government of WA.

Hodnett, E.D. (1998) *Continuity of care givers during pregnancy and childbirth* (Cochrane Review), Oxford:

Hodnett, E.D. (2001) *Home-like versus conventional institutional settings for birth* (Cochrane review). The Cochrane Library 2,

Homer, C., Davis, G. and Brodie, P. (2000) What do women feel about community-based antenatal care? *Australian and New Zealand Journal of Public Health* 24, 590-595.

Homer, C.S.E., Davis, G.K., Brodie, P.M., Sheehan, A., Barclay, L.M., Wills, J. and Chapman, M.G. (2001a) Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard care. *British Journal of Obstetrics and Gynaecology* 108, 16-22.

Homer, C.S.E., Matha, D., Jordan, L.G., Wills, J. and Davis, G.K. (2001b) Community-based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review* 24, 85-93.

Kaufmann, T. (2002) Midwifery and Public Health. *MIDIRS Midwifery Digest* March, S23-S26

Kenny, P., Brodie, P., Eckermann, S. and Hall, J. (1994) *Westmead Hospital Team Midwifery Project Evaluation: Final Report.* Sydney, NSW: Westmead Hospital.

Lane, K. (2001) Multiple visions or multiple aversions? Consumer representation, consultation and participation in maternity issues. *Annual Review of Health Social Sciences* 10, 43-52.

Lane, K. (2002) Midwifery: a profession in transition. *Australian Journal of Midwifery* 15:2. 26-31.

Larkin, G. (1983) *Occupational Monopoly and Modern Medicine*, London: Tavistock.

Lavender, T., Bennett, N., Blundell, J. and Malpass, L. (2001) Midwives' views on redefining midwifery 3: continuity of care. *British Journal of Midwifery* 10, 18-22.

Leap, N. and Barclay, L. (2002) *National Review of Midwifery Education - Report to the National Review of Nursing Education*, Canberra: Department of Education, Training and Youth Affairs and the Department of Health and Aged Care.

MacVicar, J., Dobbie, G., Owen-Johnstone, L., Jagger, C., Hopkins, M. and Kennedy, J. (1993) Simulated home delivery in hospital: a randomised controlled trial. *British Journal of Obstetrics and Gynaecology* 100, 316-323.

Mason, J. (2001) Defining midwifery practice. *Association for Improvements in the Maternity Services (AIMS) Journal* 12, 5-6.

Maternity Coalition and et al (2002) *National Maternity Action Plan for the introduction of Community Midwifery Services in urban and regional Australia.* Available from http://www.communitymidwifery.iinet.net.au/nmap.html.

Nassar, N. and Sullivan, E.A. (2001) *Australian Mothers and Babies 1999*, Sydney: AIHW National Perinatal Statistics Unit.

NHMRC (1996) *Options for effective care in childbirth.* Canberra: Australian Government Printing Service.

NHMRC (1998) *Review of services offered by midwives*, Canberra: Commonwealth of Australia.

NSW Health Department (1996) *NSW Midwifery Taskforce Report.* State Health Publication No. (NB) 960017, Sydney: NSW Department of Health.

NSW Health Department (2000) *The NSW Framework for Maternity Services.* (NB) 000044, Sydney: Better Health Centre Publications.

NSW Health Department (2001) *Report of the review of the Nurses Act 1991*, NSW Health Department:

Pinch, C., Della, P., Margrie F and (eds) (2001) *Report of the West Australian Study of Nursing and Midwifery*, Perth: Department of Health Western Australia.

Pope, R. and et al (1996) *Identification of the changing educational needs of midwives in developing new dimensions of care in a variety of settings and the development of an educational package to meet those needs.* London: English National Board for Nursing, Midwifery and Health Visiting.

Reiger, K. (2001) The politics of midwifery in Australia: tensions, debates and opportunities. *Annual Review of Health Social Sciences* 10, 53-64.

Roberts, C., Tracy, S. and Peat, B. (1999) Rates for obstetric intervention among private and public patients in Australia: population based descriptive study. *British Medical Journal* 321, 137-141.

Rooks, J.P., Weatherby, N.L., Ernst, E.K.M., Stapleton, S., Rosen, D. and Rosenfield, A. (1989) Outcomes of care in birth centres. The National Birth Centre Study. *New England Journal of Medicine* 321, 1804-1811.

Rosser, J. (1998) Caesarean sections: effective policies for risk management. *The Practising Midwife* 1, 9-10.

Rowley, M.J., Hensley, M.J., Brinsmead, M.W. and Wlodarczyk, J.H. (1995) Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia* 163, 289-193.

Sandall, J. (1997) Midwives' burnout and continuity of care. *British Journal of Midwifery* 5, 106-111.

Sikorski, J., Clement, S., Wilson, J., Das, S. and Smeeton, N. (1995) A survey of health professionals' views on possible changes in the provision and organisation of antenatal care. *Midwifery* 11, 61-68.

Stafford, S. (2001) Lack of autonomy - A reason for midwives leaving the profession? *The Practising Midwife* 4, 46-47.

Stevens, T. and McCourt, C. (2002) One-to-one midwifery practice: meaning for midwives. *British Journal of Midwifery* 10, 111-115.

Strauss A & Corbin J (1990) *Basics of qualitative research - grounded theory procedures and techniques.* California: Sage Publications.

Summers A. (1998) The lost voice of midwifery; Midwives, Nurses and the Nurses Registration Act of South Australia. *Collegian* 5, 16-22.

Tracy, S., Barclay, L. and Brodie, P. (2000) Contemporary issues in the workforce and education of Australian midwives. *Australian Health Review* 23, 78-88.

Waldenström, U. and Nilsson, C.A. (1993) Women's satisfaction with Birth Centre care: A randomised controlled trial. *Birth: Issues in Perinatal Care and Education* 21, 3-13.

Walsh, D. (2000) Evidence based care series 2: Free-standing birth centres. *British Journal of Midwifery* 8, 351-355.

Willis, E. (1983) *Medical dominance: the division of labour in Australian health care*, Sydney: Allen & Unwin.

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

Zadoroznyj, M. (2000) Midwife-led maternity services and consumer 'choice' in an Australian metropolitan region. *Midwifery* 17, 177-185.