



The role of the midwife in Australia: views of women and midwives

Caroline S.E. Homer, RM, PhD (Professor of Midwifery)^{a,*}, Lyn Passant, RN, RM, MMid (Project Officer)^a, Pat M. Brodie, RN, RM, MN, DMid (Professor of Midwifery)^b, Sue Kildea, RN, RM, BHlthSc (Hons), PhD (Senior Research Officer)^a, Nicky Leap, RM, MSc, DMid (Director of Midwifery Practice, Associate Professor)^{a,c}, Jan Pincombe, RM, RN, MAppSc, PhD (Professor of Midwifery and Program Director of Midwifery)^d, Carol Thorogood, RN, RM, MPhil, PhD (Senior Lecturer in Midwifery)^e

^a*Faculty of Nursing, Midwifery and Health, Centre for Midwifery, Child and Family Health, University of Technology Sydney, P.O. Box 123, Broadway, NSW 2007, Australia*

^b*Sydney South West Area Health Service and University of Technology Sydney, Sydney, Australia*

^c*South Eastern Sydney and Illawarra Area Health Service, University of Technology Sydney, Sydney, Australia*

^d*Department of Nursing and Midwifery, University of South Australia, Australia*

^e*School of Nursing and Public Health, Edith Cowan University, Perth, Australia*

*Corresponding author. E-mail address: Caroline.Homer@uts.edu.au (C.S.E. Homer).

Received 9 November 2005; received in revised form 9 February 2006; accepted 12 February 2006

Summary

Objective: to research the role of midwives in Australia from the perspectives of women and midwives. This study was part of a commissioned national research project to articulate the scope of practice of Australian midwives and to develop national competency standards to assist midwives to deliver safe and competent midwifery care.

Design: a multi-method approach with qualitative data collected from surveys with women and interviews with midwives.

Setting: participants represented each state and territory in Australia.

Participants: midwives who were randomly selected by the regulatory authorities across the country and women who were consumers of midwifery care and involved in maternity activism.

Key conclusions: midwives and women identified a series of key elements that were required of a midwife. These included: being woman centred; providing safe and supportive care; and working in collaboration with others when necessary. These findings were consistent with much of the international literature.

Implications for practice: a number of barriers to achieving the full role of the midwife were identified. These included a lack of opportunity to practice across the full spectrum of maternity care, the invisibility of midwifery in regulation and practice, the domination of medicine, workforce shortages, the institutional system of maternity care, and the lack of a clear image of what midwifery is within the wider community. These barriers must be addressed if midwives in Australia are to be able to function according to the full potential of their role.

© 2007 Published by Elsevier Ltd.

Keywords Role of the midwife; Australia

Introduction

In 2004, the Australian Nursing and Midwifery Council (ANMC) commissioned a national research project to articulate the role and scope of practice of Australian midwives, and to develop national competency standards to ensure that midwives provide safe and competent midwifery care (Homer et al., 2005). This paper reports on the part of the project that investigated the role of the midwife in Australia. The larger project included workshops with midwives, interviews with regulatory boards and other key stakeholders, and observations of midwives in practice. The results of these aspects of the wider research are reported in separate publications (Homer et al., 2007).

A number of changes have occurred in recent years in Australia, which have impacted on the role of the midwife. Recent Australian reports have recognised the changing role of the midwife in relation to 'new models' of care and the need for midwives to further develop their skills in order to take responsibility and work to the full potential of their role (NHMRC, 1996, 1998; AMWAC, 1998).

Across Australia, a range of different models of maternity care exists. Availability and competence of the maternity workforce, resources and authority for decision making are some of the factors influencing the models of care currently offered. Midwives are taking a leading role in the development, implementation and evaluation of these models with a view to ensuring that they reflect the principles of women-centred continuity of midwifery care. At policy level, midwives are also influencing changes in systems of care and service birth. The role of the midwife in Australia needs to embrace these contemporary issues, particularly the need for midwives to work to the full extent of their capacity and education.

Anecdotally, there has been debate about what the stated role of the midwife should be. Research into the role of the midwife had not previously been undertaken in Australia and there is still some confusion in this country about 'what it is that midwives do'. There is also dissent about how articulation of the role of the midwife can assist in setting future directions for midwifery in Australia. There is one school of thought which suggests that the stated role should reflect 'what currently is'. Another view is that any stated role should reflect what 'should' or 'could' be in the future. The international definition of a midwife (ICM, 2005) provides scope for midwives to practice according to the full potential of the role. While this definition is not universally used in its original form, the intent is nonetheless similar in all

Western countries where midwifery is a profession in its own right.

In Australia, recognition that midwifery is a separate profession to nursing and midwifery has been a recent phenomenon and has been surrounded by considerable debate and discussion within both professions. This atmosphere of change and debate supported the commissioning of this research by the ANMC who represent the regulatory bodies for nursing and midwifery around the country.

Method

A multi-method approach (Sandelowski, 2000) was undertaken in order to develop a thorough understanding of the role of the midwife in Australia. Qualitative data and simple descriptive statistics were collected from surveys and interviews. Approval from the Human Research Ethics Committees from the three participating universities was obtained before commencement.

Women's surveys

Women's surveys were used to collect the views of women as consumers. These surveys addressed what women wanted from midwives and what they saw as the role of the midwife. The survey asked: 'Can you think about a situation when you experienced midwifery care and then briefly respond to these questions?' and then asked: 'What was the situation? What did the midwife do that was important or useful? Is there anything that you would like midwives to do in order to give good care to women? Is there anything else you would like to tell us that would help inform this project?'

Branches of the Australian College of Midwives (ACM) and Maternity Coalition in each state and territory were each sent five survey forms ($n = 80$). The ACM is the peak professional organisation for midwives in Australia and the Maternity Coalition is a national non-profit, non-political and non-sectarian consumer advocacy organisation that brings together support groups and individuals for effective lobbying, information sharing, networking and support in maternity services. These organisations were asked to distribute the survey forms among their members. A total of 28 surveys (35% response) were received from women (Table 1).

Most respondents ($n = 20$) were from metropolitan areas, with two from rural areas and another two from remote settings. Four women did not indicate where they lived (Table 2). This distribution is

Table 1 The number of respondents by state and territory of residence.

| Australian state and territory | | | | | | | |
|--------------------------------|-----|-----|-----|-----|----|-----|----|
| WA | VIC | TAS | ACT | NSW | NT | QLD | SA |
| 3 | 6 | 3 | 2 | 2 | 6 | 4 | 2 |

ACT, Australian Capital Territory; NSW, New South Wales; NT, Northern Territory; QLD, Queensland; SA, South Australia; TAS, Tasmania; VIC, Victoria; WA, Western Australia.

Table 2 Geographic location of midwives interviewed.

| Australian state and territory | | | | | | | |
|--------------------------------|-----|-----|-----|-----|----|-----|----|
| WA | VIC | TAS | ACT | NSW | NT | QLD | SA |
| 5 | 3 | 3 | 8 | 5 | 3 | 1 | 4 |

ACT, Australian Capital Territory; NSW, New South Wales; NT, Northern Territory; QLD, Queensland; SA, South Australia; TAS, Tasmania; VIC, Victoria; WA, Western Australia.

broadly representative of the geographic location of people in Australia.

Midwives' interviews

Telephone interviews were conducted with 32 midwives randomly selected from around Australia. The aim of the interviews was to identify and discuss situations that midwives encounter in daily practice, and from these build a picture of 'what midwives do' and the attributes they need to do it in order to fulfil their role. The eight separate regulatory authorities for midwives and the ACM randomly distributed 80 letters and consent forms inviting midwives to participate in the telephone interviews. The aim was to conduct 32 interviews—approximately four from each of the eight states and territories in the country. This number was decided through discussions with the research team and the regulatory authorities to obtain some representation from all states and territories. The large numbers of invitations were sent because most of the regulatory authorities in Australia are unable to distinguish between currently practising midwives and practising nurses with midwifery qualifications from their registers. The registers in most states and territories can only determine who holds a midwifery qualification.

Midwives who agreed to participate contacted the research team by returning a signed consent form. Appointments were then made with the individual participants at a convenient time. The telephone interviews took, on average, 30 minutes with the duration being led by the midwife being interviewed. Participants were asked to recall experiences that demonstrated midwifery practice and that were of special significance to them or where they felt they had made an impact on a woman's experience.

The interviews and analysis used a methodology known as critical incident technique (CIT) (Ash et al., 1992; Ballantyne et al., 1998). The interviewer, a midwife, conducted all of the interviews, following training on interview techniques. The phone interviews occurred from September to November 2004. Each interview was transcribed into a Word document. The data were converted into ATLAS-TI, a qualitative software programme, for analysis. Two researchers individually examined each 'critical incident' detailed in the interviews to elicit the beliefs and attitudes in relation to the role of the midwife. These descriptors of the role were given codes and grouped according to common themes. A third researcher examined the codes and themes, and assisted with the development of sub-categories, categories and main categories. The process was iterative and consensus about the role of the midwife was developed through re-reading the transcripts and reflecting on the interviews and the incidents that described 'what midwives do.'

Findings

Women's views

Of the 28 survey respondents, 10 had given birth at home with an independent midwife, nine had given birth in a hospital, including a co-located birth centre, seven had experienced both home and hospital births, and one did not indicate where she had given birth.

The two main categories that described the role of the midwife were: *professional capacities* and *personal qualities*. These will be discussed in the next section, drawing out the sub-categories under each.

Professional capacities

There were four main roles identified under professional capacities. Essentially, these capacities were 'what women wanted midwives to provide'.

Skilled care was a strong theme through all the data. Women wanted midwives to provide *competent and expert care* that was *up to date* and based on evidence. This category included the need to provide fundamental 'health checks' on the woman and her baby, and to use skills and expertise to *keep the process safe and 'normal'*.

Women needed their midwives to provide information. This included answering questions, giving advice, informing about options and providing information about expectations and possible realities. Advice about nutrition and breast feeding, and information about pregnancy, birth and the postnatal period, and possible risks were the strongest themes under this category.

The provision of *reassurance* was also important for midwives to provide. This included *confidence in the woman's ability* and *making time to be available*, to have *time to listen and to support women to achieve their potential*.

Finally, women wanted midwives to provide *continuity of caregiver*. This meant having a midwife who they knew, trusted and had a relationship with. Having midwives who remembered them and their story and who they could trust was important. Continuity included fulfilling an *advocacy* role and the provision of *culturally appropriate care*. These roles were linked to 'continuity of caregiver', because it appeared that if the midwife knew the woman and understood her history, past experiences and needs, she would be able to act as an advocate and have an awareness of cultural issues. Continuity of care was a strong theme throughout the data. Three-quarters of women made specific reference to continuity of midwife during pregnancy, labour and birth.

Personal qualities

Again, there were four main roles identified under personal qualities. Essentially, these qualities were 'what women wanted midwives to have'.

Women wanted midwives to *have confidence in women's ability* to give birth and to acknowledge women's own strength. They wanted midwives to have the ability to 'do nothing unless something is wrong' and to be able to put women first. Midwives who had a philosophy of confidence and encouragement and who were positive, strong and supportive, especially during labour, were highly valued.

Women wanted midwives to have *excellent communication skills*. This included being able to supply information but was also deeper than this. Women needed to be partners in the sharing of information with midwives who were able to listen to them and accept their judgments and decisions.

Women also wanted midwives to be able to *collaborate* with others when other care was required. For example, working well with doctors, other midwives and hospital staff in an integrated way was seen as important and highly valued. Women wanted midwives to have respect for other care providers and to be able to work together when it was necessary.

Finally, women wanted midwives to have *greater visibility* in the community. This was seen as a way to increase the profile of midwives and to improve respect and autonomy; both factors that women saw as vital to the promotion of midwifery.

Midwives' views

All 32 midwives who responded to the invitation were interviewed, representing each state and territory. Table 2 presents the distribution of respondents. Just over half were from metropolitan areas, one-third were from rural areas and the remainder were from remote settings. Remote settings were defined by the Australian Bureau of Statistics (ABS) which measures remoteness based on the road distance from any point to the nearest service centre (ABS, 2001).

Current place of employment ranged from public hospitals, midwifery models of care to a small number in community-based, private or other models of care (Table 3). This is representative of midwives in Australia where most work in hospital-based settings.

Midwives described a range of clinical scenarios in their interviews. The most common involved the role of advocacy and negotiation to ensure the best outcome for the woman and her baby and the provision of continuity of caregiver. Other scenarios involved the provision of supportive care, supporting normal birth and involvement with challenging situations, e.g. emergencies, drug and alcohol use, and supporting breast feeding.

There were three main categories that described 'what midwives do' and the attributes and attitudes they need to undertake their role. These categories described the skills and knowledge required, the philosophical beliefs and attitudes they needed to possess, and the environment that impacted on their role and scope of practice.

Attributes and knowledge

The need for particular attributes and knowledge was recognised by all midwives in the study. These included understanding the *processes of pregnancy, labour, birth and the postnatal period* and being able to provide *competent and safe clinical care* to

Table 3 Model of care in which midwives were currently working.

| Public hospital | Midwifery model of care | Private hospital | GP-led or other model | Community-based model |
|-----------------|-------------------------|------------------|-----------------------|-----------------------|
| 16 | 10 | 2 | 3 | 1 |

- *Public hospital*: Mostly traditional fragmented model with midwives working in different areas without providing continuity of care. This is the dominant form of maternity care in Australia.
- *Midwifery model of care*: Generally provide continuity of care across antenatal period, labour and birth, and the postnatal period.
- *Private hospital*: Midwives only provide care during labour and birth and the postnatal period. Generally, births are attended by private obstetricians and there are limited community midwifery services.
- *GP-led model*: Model where general practitioners provide the bulk of antenatal care and often attend the births especially in rural areas. Midwives provide care in the postnatal period, sometimes in the community.
- *Community-based*: Similar to midwifery-led services but based in the community. This model of care is not widespread or common in Australia.

women and their babies throughout this time. Specific attributes included being able to observe women and their babies and undertake assessments and provide clinical care, including supporting breast feeding. The role of the midwife also involved having the confidence to *negotiate* with other care providers, especially medical staff, *advocating* for women and being able to *challenge practice* when appropriate or necessary. These challenges were seen as being undertaken within a culture that respected the abilities of other members of the health care team and ensured collaborative practice.

Communication skills, including *listening*, the provision of *accurate information*, discussing *options* and *answering questions* were all seen as important. Almost every respondent in the study mentioned the need for communication skills. Midwives recognised the need for knowledge and practice to be based on *evidence*.

The ability to *provide support*, including social and physical support, was seen as part of the role of the midwife. This included assisting women to care for their babies and supporting their families. Support also included providing reassurance, building confidence, allaying anxiety and fear, and reinforcing the woman's choices.

The focus on *ensuring a safe outcome* was a strong sub-category. This included being able to manage emergencies and being aware of one's own boundaries. An ability to undertake effective referral and consultation were identified as being essential.

The role of the midwife included having *intuition and instinct*. Having *confidence* and being a *role model or mentor* were also identified as being important, as was a *commitment to life-long learning, reflective practice and self awareness*.

An ability to provide *education and support of students and other midwives* was also seen as important. A number of midwives also mentioned the need to care for oneself and one's colleagues as part of the role of the midwife. Being able to *delegate and manage* situations were identified as being important components of the role.

An understanding of the importance of evaluation was also viewed as part of the role of the midwife. This involved asking women about their care and reflecting on the responses.

Philosophical beliefs and attitudes

The category, philosophical beliefs and attitudes, predominately encompassed the attitudes that midwives needed to possess in their role.

Believing in the birth process and in women's abilities to give birth were seen as part of the role. This included being able to trust the 'natural process' while providing a safe environment, *trusting women* and believing that women understand their own bodies.

A capacity to work in an *enabling or 'empowering'* way was seen as important. This included working in *respectful partnerships* with women to ensure that they develop confidence and are able to make decisions for themselves. *Respecting women's choices* was also seen as part of working in a respectful partnership.

Being *non-judgmental, open-minded, honest and culturally aware* were seen as essential. This was important in the interactions with women but also in the presentation of information. Having *compassion* and respecting the privilege of working alongside women was highlighted by a number of midwives. Being able to maintain *confidentiality* was also seen as necessary.

The capacity to develop *trusting relationships* with individual women was highlighted. This included getting to know the woman, listening, developing rapport and providing individualised care. *Having, or making, time, being accessible and not being rushed* were also essential to enable the development of relationships. These factors were also part of midwives 'being with women' which was mentioned by a number of respondents. This included understanding what women want, being unobtrusive but available, not leaving women alone in labour and not 'doing' too much. The other side of the relationship development was the need to not create dependencies but to *encourage women to seek their own relationships*.

Providing woman-centred care was seen as a way of working rather than a particular organisational model. Ensuring women have control over their care, focusing on their needs and being receptive to different approaches were part of this capacity to work in a woman-centred way. *Being flexible* within the role and *supporting the family* were components of this approach.

The personal manner of the midwife was also noted. Being *positive, calm but confident, professional, sensitive and friendly* were all important components of the midwife's role.

Environment of care

Midwives discussed a number of environmental issues that were significant in considering their role and scope of practice. While these are not specifically part of the role or the knowledge, skills and attitudes required by midwives, they undoubtedly have an impact on the practice of midwifery in Australia.

Most midwives recognised that the provision of *continuity of care* was ideal. Knowing the woman, having a consistent philosophy and being able to provide one-to-one care were all seen as part of the concept of continuity of care. One midwife said, 'My job is easier if I know her' and another acknowledged that information was 'less conflict-ing' if continuity could be provided.

While continuity of care was thought to be ideal, the *barriers* to all midwives being able to provide this model of care were seen as considerable. These included organisational or institutional barriers which revolved around a lack of flexibility in health systems and managers; perceived costs involved; lack of transport to provide care in the community; and medical dominance. All of these factors were seen as preventing midwives from working according to their full role. Personal issues were also seen to prevent midwives from providing continuity of care. This included family

responsibilities and social commitments. Some midwives were supportive of others providing continuity of care, but were unwilling to provide it themselves. There was also a perception that many midwives are not able to provide the full scope of midwifery practice; in particular, they are unable to work in a caseload practice model.

Systems that enable midwives to work collaboratively were valued. The components of supportive systems included *effective communication and consultation and referral* between professionals. A collaborative relationship with medical colleagues was seen as an important aspect of midwifery practice.

Collaboration also included working with others when the care of women falls outside the midwives' scope of practice. For example, the care of women with mental health conditions was seen as one area where collaboration was particularly needed.

The political context in which midwives work also impacted on the role and scope of practice. The *invisibility of midwives* within the Australian health system was raised as a concern by a number of respondents. This was identified as leading to frustration and a desire for greater recognition.

Matching the views of women and midwives

Analysis of the role of the midwife from the perspectives of women and midwives is shown in Table 4. This process was undertaken to determine the degree of agreement that existed between the perceptions of women and midwives with regard to the role of the midwife.

Both women and midwives recognised the need for particular attributes and knowledge, and these incorporated specific skills as well as broad notions of philosophical underpinnings to practice. Aspects of knowledge, support, trust, flexibility, continuity, confidence, encouragement and effective communication were all intertwined as important components of the role of the midwife.

The only area where there was not a degree of agreement was in relation to the midwives' continuing professional development needs and the issues of delegation and management. This is understandable as it is unlikely that the issues of professional development, evaluation, delegation and management would be a visible part of the midwife's role from the woman's perspective. It is likely that women would see these as underpinning midwifery practice and essential to ensuring a high level of care, but not necessarily overt to the public.

Table 4 Analysis of the views of women and midwives about the role of the midwife.

| Women's views | Midwives' views |
|--|--|
| Provides skilled care that is up to date and based on evidence | Has skills and knowledge about pregnancy, labour, birth and the postnatal period for the woman and her baby Provides competent and safe clinical care Bases practice on evidence Provides care to ensure a safe outcome Manages emergencies |
| Has a philosophy of encouragement that is strong and supportive | Provides woman-centred care Works in an enabling or 'empowering' way Has respectful partnerships with women and others Provides support Is non-judgmental, open-minded, honest and compassionate Has intuition and instinct Is professional yet sensitive and friendly Maintains confidentiality Encourages women to develop their own networks Supports the family |
| Works in an advocacy role | Is an advocate Respects women's choices Challenges practices |
| Provides continuity of caregiver | Provides continuity of care and carer when possible Builds trusting relationships with women Is flexible Acknowledges the barriers to continuity of carer |
| Provides culturally appropriate care | Is culturally aware |
| Provides information and advice | Communication skills include listening, providing accurate information, discussing options and answering questions |
| Answers questions Informs about options Provides information about expectations and possible realities Collaborates with others | Works collaboratively Undertakes appropriate consultation and referral Is aware of own boundaries |
| Has time to listen | Having, or making, time Being accessible and not rushed |
| Provides reassurance | Provides reassurance Builds confidence and allays anxiety |
| Helps keep the process normal Has confidence in the woman's ability Supports women to achieve their potential | Believes in the birth process and in women Has confidence in women's abilities |
| Is positive | Being positive Being calm but confident |
| Requires greater visibility in the community | Concerned about the invisibility of midwives |
| No comments | Is a role model or mentor Is committed to life-long learning, reflective practice and self awareness Involved in ongoing evaluation Assists with education and support of students and others Delegates and manages |

Discussion

This research has a number of limitations. Firstly, only a small proportion of midwives were sampled. While it would not have been possible to interview large numbers of midwives due to the nature of the method, the sample does represent the broad range of midwives who work in maternity care in Australia. Each state and territory was represented and respondents worked in a range of models of care, including public and private hospitals and midwifery-led services. These are broadly representative of the diversity of model of care options available in Australia.

Secondly, the women who responded to the survey were not representative of all women giving birth in Australia. Seventeen of the 28 women had given birth at home. In the most recent annual report on mothers and babies in Australia, home births accounted for less than 1% of births (Laws and Sullivan, 2004). Nonetheless, it could be argued that women who seek home births are those who are most informed about the role of the midwife. It appears that this group of women understand what midwives do, and are representative of women who seek out that particular type of care, including continuity of care, and motivated to respond to surveys. Therefore, while this is a select and non-representative group, they are in an informed position to describe the role of the midwife. In addition, it was not possible to explore the meaning of the phrases used by women or the nature of their birth experiences more deeply as the data were collected using written surveys. An interview approach would provide a deeper analysis of these issues for women.

Many of the aspects of the role of the midwife illustrated in this research have been previously identified in similar studies. Research undertaken in the UK to explore the views of consumers in developing a model of competence also demonstrated that the personal qualities of the midwife, such as being friendly, reassuring and calm, were important (Fraser, 2000). Other key issues in the UK research were good communication skills, allowing the couple to be in control, expert clinical skills and the ability to make professional judgments. Other research in the USA also demonstrated that supporting the normality of pregnancy and birth, vigilance and attention to detail, and respecting the uniqueness of the woman were important aspects of the role of the midwife (Kennedy, 2000). Having respect for women's time, their families, their fears and their need for information has also been shown to be part of the essence of the role of the midwife (Kennedy, 1995).

A metasynthesis of midwifery practice in the USA identified four themes that described midwifery

care. These were: the midwife as an 'instrument' of care; the woman as a 'partner' in care; an 'alliance' between the woman and the midwife; and the 'environment' of care (Kennedy et al., 2003). These themes again are similar to those identified in this Australian research.

While the midwives interviewed were able to articulate the role of the midwife in Australia, almost all recognised that fulfilling the role in relation to the *International Definition of the Midwife* (ICM, 1992) was not always possible as considerable barriers existed. The barriers to achieving the full role and scope of practice have previously been identified in Australia. The Australian Midwifery Action Project identified the barriers and current problems in the organisation of maternity care in Australia (Brodie, 2002; Leap, 2002; Leap et al., 2003). These included the invisibility of midwifery within the community including in regulation in some states, the domination of medicine and the lack of opportunities to practice across the full spectrum of maternity care. Workforce shortages, the institutional system of maternity care, and the lack of a clear image of what midwifery is also constitute significant barriers. These barriers need to be addressed and the role of the midwife fully and clearly articulated if midwives are to be able to function according to the full role and scope as articulated by the ICM.

The barriers to achieving the full role and scope of practice contribute to workforce shortages. Shortages in the current midwifery workforce have been previously identified in an Australian Health Workforce Advisory Committee Report (AHWAC, 2002). The optimal use of workforce skills to ensure best health outcomes has been acknowledged by the AHWAC as a guiding principle of workforce planning (AHWAC, 2004). The 2002 report recognised that a re-alignment of workforce roles may be necessary. Ensuring that practitioners can perform the role for which they were educated is a fundamental aspect of maintaining a healthy workforce. In addition, the lack of consistent standards of education and practice (Tracy et al., 2000; Leap and Barclay, 2001; Leap, 2002; Leap et al., 2003) will potentially continue to present challenges.

Conclusion

This study was the first phase of a larger project that examined the role and scope of practice of the Australian midwife, and developed national competency standards for the midwife (Homer et al., 2007). This is the first time that a study such as this has been conducted in Australia.

Midwives and women identified a series of key elements that were required of a midwife. These included: being woman centred; providing safe and supportive care; and working in collaboration with others when necessary. These findings were consistent with much of the international literature.

A number of barriers to practising to the full role of the midwife were identified. These included: a lack of opportunity to practice across the full spectrum of maternity care; the invisibility of midwifery in regulation and practice; the domination of medicine; workforce shortages; the institutional system of maternity care; and the lack of a clear image of what midwifery is within the wider community. These barriers must be addressed if midwives in Australia are to be able to function according to their full role.

A clear articulation and understanding of the role of the midwife is essential if Australian midwifery and maternity services are going to be able to provide woman-centred care to the majority of childbearing women. This clear articulation has implications for regulation, education, ongoing professional development, and community awareness of the role, and value, of a midwife in Australia.

Acknowledgements

The authors thank the midwives and consumers who participated in this research, and acknowledge the contribution of the Reference Group and the international technical advisors, Dr. Sally Pairman from the New Zealand Midwifery Council and Professor Diane Fraser from the University of Nottingham in the UK. The authors also thank Joanna Leonard from the University of Technology Sydney for assistance in preparation of this manuscript. This research was funded by the Australian Nursing and Midwifery Council.

References

ABS, 2001. Information Paper—ABS Views on Remoteness (ABS Cat. no. 1244.0). Australian Bureau of Statistics, Canberra.

AHWAC, 2002. The Midwifery Workforce in Australia 2002–12. Australian Health Workforce Advisory Committee, Sydney.

AHWAC, 2004. Nursing Workforce Planning in Australia. Australian Health Workforce Advisory Committee, Sydney.

AMWAC, A., 1998. The Obstetrics and Gynaecology Workforce in Australia. Australian Medical Workforce Advisory Committee, NSW Department of Health, Sydney.

Ash, S., Gonczi, A., Hager, P., 1992. Combining research methodologies to develop competency-based standards for dieticians: a case study for the professions. Research Paper No. 6. National Office of Overseas Skills Recognition, AGPS, Canberra.

Ballantyne, A., Cheek, J., O'Brien, B., et al., 1998. Nursing competencies: ground work in aged and extended care. *International Journal of Nursing Practice* 4, 156–165.

Brodie, P., 2002. Addressing the barriers to midwifery: Australian midwives speaking out. *Journal of the Australian College of Midwives* 15, 5–14.

Fraser, D.M., 2000. Action research to improve the pre-registration midwifery curriculum. Part 3: Can fitness for practice be guaranteed? The challenges of designing and implementing an effective assessment in practice scheme. *Midwifery* 16, 287–294.

Homer, C., Pincombe, J., Thorogood, C., et al., 2005. An examination of the role and scope of practice of Australian midwives and the development of competency standards for midwifery: final report. Australian Nursing and Midwifery Council, Canberra.

Homer, C., Passant, L., Kildea, S., et al., 2007. The development of national competency standards for the midwife in Australia. *Midwifery* 23, 350–360.

ICM, 1992, 2000. International definition of a midwife. <<http://www.internationalmidwives.org/Statements/Definition%20of%20the%20Midwife.htm>> (last accessed 2005).

ICM, 2005. International Definition of a Midwife. International Confederation of Midwives, The Hague.

Kennedy, H.P., 1995. The essence of nurse-midwifery care. The woman's story. *Journal of Nurse-Midwifery* 40, 410–417.

Kennedy, H.P., 2000. A model of exemplary midwifery practice: results of a Delphi study. *Journal of Midwifery and Women's Health* 45, 4–19.

Kennedy, H.P., Rousseau, A., Kane Low, L., 2003. An exploratory metasynthesis of midwifery practice in the United States. *Midwifery* 19, 203–214.

Laws, P., Sullivan, E.A., 2004. Australia's Mothers and Babies 2002. Perinatal Statistics Series Number 15. AIHW National Perinatal Statistics Unit, Sydney.

Leap, N., 2002. Identifying the practice component of Australian midwifery education programs: results of the Australian Midwifery Action Project (AMAP) Education Survey. *Australian Midwifery Journal* 15, 15–23.

Leap, N., Barclay, L., 2001. Midwifery education: literature review and additional material. National review of nursing education. Commonwealth of Australia, Canberra.

Leap, N., Barclay, L., Sheehan, A., 2003. Results of the Australian Midwifery Action Project Education Survey. Paper 2: barriers to effective midwifery education as identified by midwifery course coordinators. *Australian Midwifery Journal* 16, 6–11.

NHMRC, 1996. Options for Effective Care in Childbirth. Australian Government Printing Service, Canberra.

NHMRC, 1998. Review of Services Offered by Midwives. Commonwealth of Australia, Canberra.

Sandelowski, M., 2000. Combining qualitative and quantitative sampling, data collection and analysis techniques in mixed method studies. *Research in Nursing and Health* 23, 246–255.

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