THE INTRODUCTION OF 'DIRECT ENTRY' MIDWIFERY COURSES IN AUSTRALIAN UNIVERSITIES: ISSUES, MYTHS AND A NEED FOR COLLABORATION

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ABSTRACT

This paper identifies some of the issues within the debate regarding the introduction of 'direct entry' midwifery education in Australia. It addresses questions that have been raised around terminology; the current midwifery education system; whether midwives also need to be nurses; how nurses who want to become midwives might enter the same programme with recognition of prior learning; and whether 'direct entry' midwifery education should become a mainstream option. A case is made for a collaborative initiative to consider all aspects of developing a national framework for Bachelor of Midwifery programmes.

Key words: Australian, midwifery, education, direct entry, collaboration.

INTRODUCTION

This paper arises from numerous discussions with women, midwives and nurses from around Australia over the last few years. It is also informed by discussions held in the course of international study tours with midwives from the United Kingdom, New Zealand, Canada and the Netherlands, plus relevant literature and my own experience.

Confusion and contradiction clearly exist within debates regarding the introduction of midwifery programmes for 'direct entry' to the profession in Australia. My intention here is twofold: to identify some of the issues and make a case for a collaborative midwifery education initiative. I propose that a task force could review 'direct entry' midwifery education in other countries and make recommendations regarding the introduction of 'direct entry' midwifery education in Australia, after a process of thorough consultation with all key stakeholders. Such an approach would ensure that the particular needs of the Australian context are addressed. It would also avoid perpetuating the present fragmented system where entry to the profession occurs at different academic levels within a wide variety of courses with different standards and frameworks, particularly regarding clinical experience, assessment and regulation (Glover, 1999:19).

The terminology debate

Confusion exists over terminology. Midwifery colleagues argue for a 'Bachelor of Midwifery' or 'Undergraduate Midwifery Programme' as opposed to using the 'Direct Entry' title (as revealed in communications on the 'ozmidwifery e-mailing list'). A similar debate took place in England. When the first new wave of three and four year courses for non-nurses were introduced in English university settings in the late 1980s, there was enthusiasm for defining them as different from the old style 'direct entry' hospital based courses that had almost ceased to exist. The new courses were therefore referred to as 'pre-registration midwifery education' with the eighteen-month courses for nurses referred to as 'post registration midwifery education'. However, when people started questioning the inappropriate nature of placing a *nursing* qualification as the pivot around which midwifery education is described (Leap 1992), a move was made to change the terminology yet again. Thus, the titles were changed so that the core registration would reflect a *midwifery* qualification, not a nursing qualification. Courses in England are now referred to as the somewhat pedestrian 'pre-registration long' and 'pre-registration short' by those in academia and officialdom. However, my impression is that in spite of all efforts to change the terminology, the prevailing phrase in everyday parlance is still 'direct entry'! In other countries, such as New Zealand, where this form of education

has become the predominant route to midwifery registration, the term 'direct entry' prevails (New Zealand College of Midwives, 1997). It remains to be seen whether this will be the case in Australia.

Since in this country there are already Bachelor of Midwifery programmes for nurses wishing to become midwives and for qualified midwives to study at degree level, and to avoid confusion, I will continue to use the words 'direct entry' in this paper.

Current midwifery education in Australia

Across Australia, initial qualification leading to midwifery registration may be at certificate, diploma, bachelor or master level (Glover, 1999:19). At every level, midwifery education is seen as an appendage to the basic qualification of nursing. According to Glover (1999:19) "What is very obvious is that currently, midwifery education in Australia is inconsistent and lacking any formal policy, direction or national standard." There is also concern across Australia about the diminishing numbers of both qualified and student midwives. A Commonwealth funded review of Australian midwifery, to include midwifery education, is currently underway and will address this issue and attempt to identify the causes of the shortage (Australian Midwifery Action Project [AMAP] funded by the Australian Research Council, Strategic Partners in Industry Research Training Award, 1998). The research proposal for this project identified concerns within the maternity care industry that midwives are graduating from Australian midwifery education programmes with varying degrees of competence and, in some cases, inadequate skills to practise according to the full potential of the midwife's role. This situation is not necessarily surprising, given the varying amounts of exposure to midwifery clinical practice within programmes. A compounding factor in some cases is that, in order to fund their midwifery education, many students continue to work as nurses, some of them even in full time employment if they are studying in distance education programmes. In the latter case, students fit their midwifery education into their spare time or take annual leave from their nursing employment in order to undertake clinical placements of questionable duration. I suggest that this fragmented experience hinders the development of an understanding of why midwifery is a separate profession from nursing. Clearly, a review of midwifery education needs to include consideration of developing a system where financial provision enables students to concentrate full time on their midwifery education.

Without undermining the recognised merits of competency based assessment, questions can reasonably be asked about how these competencies have been incorporated in midwifery education. In some states where competency based assessment has been introduced, for example south Australia, there are no longer any minimum clinical requirements for qualification. This creates a potential situation where a preceptor determines that a student is competent even though the student has attended fewer than five births. It is doubtful if anyone would argue that this is an appropriate breadth of experience to enable a new graduate to practise according to international expectations of the midwife's role (WHO 1993) or Australian recommendations for the scope and sphere of midwifery practice (NHMRC, 1996, 1998). Other states, for example New South Wales, demand proof of the achievement of both competencies and minimum clinical requirements, but still the latter fall short of those required by the regulating bodies of other industrialised countries such as those in Europe. Thus, Australian midwives can be seriously disadvantaged when they wish to work abroad.

In designing direct entry midwifery courses for Australia, we have an opportunity to address these issues and at least ensure that, across Australia, midwives qualify at a level that enables them to use the full range of midwifery skills and take responsibility for providing continuity of midwifery care. This qualifying level should also enable Australian midwives to work anywhere in the world without having to complete further education or clinical requirements.

A different sort of midwife?

During discussions at the ACMI Education Forum in Canberra in 1998, it was suggested that introducing direct entry midwifery in Australia would enable an 'alternative' type of midwife to qualify, one who works exclusively in home birth or independent practice - a midwife who addresses the needs of women who seek an alternative to mainstream care. It was also suggested that direct entry could be the vehicle for preparing indigenous midwives to work

exclusively within their communities. Whilst it is possible that direct entry trained midwives might choose to work in any of these settings, it could do them and their communities a great disservice if we created groups of midwives who were restricted to practise only in certain settings. Hopefully, Australian midwifery programmes will educate midwives who are confident and competent to respond to women's needs and who will be able to follow women through their experience of pregnancy, childbirth and the early weeks following birth, regardless of where and how the birth occurs. This will always mean being able to collaborate well with staff in mainstream maternity service provision. Midwives who are educated to work to the full potential of their role have every opportunity to negotiate and develop new systems of care such as home birth within the public health system and birth within their own communities for indigenous women. All of this also applies to midwives who have been nurses in a previous career. We should not assume that within direct entry lie all the answers to changing midwifery practice and systems of care.

Some midwifery colleagues have expressed anxiety about creating a system where school leavers may enter a three-year Bachelor programme in order to become either a nurse or a midwife. The argument is that midwifery requires mature students with life experience. Leaving aside the need to develop careful selection procedures, it is worth noting that some midwifery educators in England and New Zealand are challenging this notion. Contrary to their expectations, the drop-out rate is no higher in this group and they are impressed by the calibre of those young women [I know of no examples of young men in direct entry midwifery programmes] who are graduating into their chosen career in midwifery (personal communications with midwifery educators in England and New Zealand).

Do midwives need to be nurses too?

I was one of the last people to 'train' as a midwife in hospital based direct entry programmes in England. At the beginning of this 'training' in 1979 I was told that in order to get anywhere in my future career, I would have to train as a nurse after finishing my midwifery course. I was told that direct entry training was being phased out and nursing was an essential component of 'modern midwifery'. Ten years later, the Government provided 'pump priming' funding for first seven, and then a total of fourteen institutions across England to develop the new three and four year programmes for those who were not nurses to enter the profession of midwifery. The number of universities offering these programmes has continued to proliferate. It is remarkable that the majority of midwifery education programmes in England are now 'direct entry'. The climate has changed completely and many universities are discontinuing the eighteen-month full time courses for those who already have a nursing qualification (English National Board, 1998). Such policy decision making is not merely informed by the economic sense of supporting three-year programmes. There is recognition that this route of entry to midwifery is associated with excellence in both education and practice in all other European countries as well as more recent initiatives in Canada and New Zealand (Kent et al, 1994; English National Board 1997; Robotham, 1997; New Zealand College of Midwives (Inc), 1997; Houd et al, 1993).

Across Australia, it seems that many people believe that midwives should be nurses first in order to practise safely. This was highlighted in a public forum recently where the proposed new South Australian Nurses Bill was being debated. A fraught discussion ensued about the implications of the fact that all mention of midwifery and midwives had been removed from the new legislation, it being assumed that midwifery is a speciality of nursing. It was noted that overseas midwives educated through direct entry programmes have to register in Australia as nurses. In response to the proposition that this issue would become more pressing with the introduction of direct entry education in Australia, a senior official from the Nurses Board proposed that there were serious safety issues to consider if people were not trained as nurses first. This was compounded by a well-meaning midwife's response: "There's room for everyone. If women develop problems then the midwives who were trained as nurses first can look after those women and after all, most women are going through a normal healthy life event so the direct entry trained midwives can look after the majority of women".

The absurdity of this attitude is obvious. However, similar arguments may be used in relation to the most commonly voiced concern regarding direct entry, that of the needs of rural communities to have

dual trained practitioners. One cannot generalise about the needs of rural communities in relation to direct entry as there is enormous variation depending on the circumstances of each community. There will always be remote areas where it is important to employ practitioners who will draw on their skills in both nursing and midwifery. However, there is an increasing trend in rural areas, particularly where General Practitioner (GP) obstetricians are no longer practising, to consider re-organisation of services so that midwives in group practices offer continuity of care to women, liaising with obstetricians in regional centres where needed. The possibility of re-organising some services so that midwives work in innovative continuity of care schemes and no longer practise nursing, is also an issue in larger rural towns. When visiting a rural hospital recently where approximately 600 women give birth each year, it was notable that senior midwives working in the hospital were enthusiastic. As one midwife said: "Send them up here and then the whole system will have to be re-organised! We will be able to practise just midwifery and not have to be surgical nurses as well".

Education programmes for dual trained practitioners

In order to address the issue of dual trained practitioners, it has been suggested that we should be running double degree programmes - two years of midwifery followed by two years of nursing (Game, 1998). I suspect that both nursing and midwifery would see this as a second class and inadequate education for practitioners in either discipline. Another suggestion has been an 'add-on' year of nursing following the three-year programme, or the inclusion of "enough basic nursing to enable the direct entry midwives to work in nursing settings too" (personal communications). Such ideas would probably fill our nursing colleagues with equal dismay to that felt by some midwives regarding the reverse system whereby midwifery is an 'add on' to nursing. It will be up to the nursing profession to decide how it will educate any midwives who decide that they would also like to be nurses after qualifying as midwives through the direct entry route.

This brings me to the point of discussing how we should educate nurses who want to start a new career in midwifery or those who would like to work in areas where they will need to be practitioners in both disciplines. During a recent trip to explore the New Zealand experience of direct entry education, the midwifery educators in several cities spoke unanimously on this issue. They made strong recommendations that we should consider setting up a system in Australia whereby nurses who want to be midwives should enter the same programmes as those studying through the direct entry route. The idea is that nurses undertake an individualised 'Prior Learning Assessment Programme' in order to work out with the educators which exemptions they may have from parts of the three-year programme. Thus for example, a nurse who has been working in coronary care for 20 years may do more of the programme than a community nurse with a background in women's health. In New Zealand, nurses who felt they were being shortchanged by only being offered a one-year course to qualify in midwifery drove this initiative. They identified that the direct entry students were receiving an education that equipped them to work as autonomous practitioners and that their own course fell short of this. In New Zealand, almost all nurses who want to become midwives now qualify through a shortened version of the three-year bachelor programme and only one separate midwifery programme for nurses continues.

Some colleagues have expressed concern that one cannot expect those nurses who already have a Bachelor qualification to complete another Bachelor programme in order to become a midwife. Comparisons with routes of entry to nursing are often useful in such discussions. This argument would not be used in relation to someone who already had a Bachelor degree in another discipline, such as sociology, who wanted to become a nurse. They would be expected to undertake a Bachelor of Nursing programme. However, there is an interesting precedent in some universities where people coming into nursing who already have a degree are able to do a slightly shortened course. It should be no different for those wanting to enter the profession of midwifery who already have a degree in another discipline such as nursing. Placing someone in a Master programme purely because they already have a Bachelor of Nursing makes a mockery of academic concepts concerning Master level study. Furthermore, anyone who studies for entry into the midwifery

profession at Master level can only be building and reflecting on their nursing experience. Arguably, study at Master level in midwifery should be reserved for those with experience of midwifery to engage in critical thinking and reflection at an appropriate academic level.

In considering all of these issues, the unique characteristics of the Australian higher education sector need to be taken into consideration. In particular, the issue of university fees needs to be addressed at federal level to develop financial structures to support students of midwifery and to ensure that those who already have a Bachelor degree are not financially disadvantaged.

Midwifery control of education

The issue of direct entry midwifery education is not, as was proposed recently in this journal, about the need to guarantee "midwifery practice as a nursing activity"; it is not about "nursing" having "its opportunity to control the processes of course design, implementation, standard setting, monitoring and regulation" (Game, 1998). The introduction of direct entry midwifery education in Australia will provide the potential for *midwifery* to gain control of all processes associated with designing its own education, practice and regulation. Indeed, the mere consideration of direct entry midwifery education may well give midwives the much needed opportunity to define more clearly why midwifery is a separate profession to nursing. It may also lead us to consider that the existing structures, regulations and terminology are appropriate for nursing but inappropriate for midwifery.

Recommendations for future action: a collaborative approach

Having studied how direct entry midwifery programmes have been introduced in the UK, New Zealand and Canada, I am persuaded that the introduction of direct entry midwifery education in Australia needs to be considered carefully within a collaborative effort across states and territories. As occurred in these other countries, several universities should ideally start the new courses in tandem, preferably with federal government financial support and endorsement. The competitive nature of each university trying to set up direct entry courses in isolation, could have serious consequences for midwifery in terms of a new set of courses that are as disparate and fragmented as the ones that currently exist. Furthermore, the thought of twelve lonely direct entry students qualifying in three years time from one university, having to carry the flag for direct entry is distressing. Potentially, they would be struggling in a climate that, in the main believes that you cannot be a safe midwife if you are not a nurse and may even be openly hostile.

There are universities seriously considering developing direct entry midwifery programmes in almost all Australian states and territories. Reasonably, a concerted, collaborative effort is vital if we are to develop a national system of midwifery education, regulation and practice in keeping with developments at a global level.

This means a commitment to taking time to work out the potential implications of all decisions and not 'rushing' the process. It means a process of complex negotiation and consultation at local and federal government level. As stated at the ACMI Education Forum in Canberra in 1998, my proposal is for a coordinated initiative* through the ACMI comprising :

- A Direct Entry Midwifery Task Force composed of representatives of key stakeholders from across Australia to liaise with Federal Government in considering all aspects of this development including routes of funding, implementation and demonstration projects.
- A national register of interested parties who wish to be informed of developments, including those who wish to apply to enter the profession through the direct entry route.

* *I am prepared to coordinate this initiative*

CONCLUSION

There are further advantages that could be explored, in learning from the New Zealand, Canadian and British experience and developing Bachelor programmes that become the national route of entry to midwifery in Australia. I propose that we collaborate and develop a system where individual universities develop their own curricula within an overall framework that sets national standards of the highest quality. Australian midwifery educators could develop courses that would attract the same international acclaim as those degree programmes developed by our Australian nursing colleagues for

entry to the nursing profession. The aim is to produce midwives who will be able to work as practitioners developing innovative ways of working 'with women'. It is also to design education programmes that will enable qualifying midwives to work in any setting throughout the world, regardless of whether or not they also have a nursing qualification.

As the introduction of direct entry midwifery education in Australia is controversial, this paper shall hopefully promote debate through this Journal and other avenues - as part of a process of moving forward together in the interest of developing Australian midwifery.

Post script

The ACMI Philosophy and Position Statement regarding 'direct entry' [referred to as 'pre-registration midwifery education' in line with the current terminology in the UK in 1989 when it was written] states that:

The Australian College of Midwives supports the principle of Pre-Registration Midwifery Education. Courses should be conducted in a higher education institute at an undergraduate level of a minimum duration of three years.

The Australian College of Midwives, being the professional body for midwives is the appropriate organisation to take on a role of significant consultation of the philosophical approach and content of all pre-registration midwifery courses.

Graduates of those courses would:

- Be authorised by registering authorities to practice midwifery, and
- Be eligible to use the title - MIDWIFE

(ACMI Philosophy & Position Statements, 1989, 2.2.0 Pre-Registration Midwifery Education Education)

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