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Collective action for the development of national standards for midwifery education in Australia

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ABSTRACT

This article describes a sequence of events that led to the development of national standards for the accreditation of Australian midwifery education programmes for initial registration. This process occurred within a climate of polarised opinions about the value of the introduction of three-year degree programmes for midwives who are not nurses (known as the BMid in Australia) and concerns about the invisibility of midwifery within nursing regulation, education, policy and nomenclature.

Concerted efforts to develop standards to inform the introduction of BMid programmes through a process of collective action are described. This involved arguing successfully for the positioning of midwifery as a separate profession from nursing, with a need for its own discreet regulation.

1. Introduction

This paper summarises events that occurred during the introduction of three-year Bachelor of Midwifery (BMid) programmes in Australia and processes that eventually led to the development of national standards for the accreditation of all Australian midwifery education programmes for initial registration. The authors draw on relevant literature and our lived experiences of this era, spanning from the mid-1990s until 2004. During this time, all three of us were engaged in doctoral work, based in an action oriented research process, the Australian Midwifery Action Project (AMAP). Evidence generated in the AMAP project identified the need for radical reforms in midwifery education programmes and the rationale for the regulation of midwifery as a separate profession to nursing.[1,2]

2. Early concerns about midwifery education in Australia

In the 1980s, Lesley Barclay highlighted problems associated with the regulation of midwifery education in Australia within policies and standards controlled by nursing.[3–7] This crucial body of work identified issues that were hindering Australian midwives from practising fully according to the World Health Organization's original 'Definition of a Midwife' (1966)[8]:

- Regulation in most states did not describe, define or set appropriate standards for midwifery education and practice
- Regulation was idiosyncratic and inconsistent, rendering midwifery invisible within nursing
- Midwifery education was inconsistent between states and territories, with major differences in the award, length of programmes and theory, practice and assessment elements
- A limited view of midwifery was demonstrated by some nursing leaders who were in a decision-making capacity on behalf of midwifery

These issues continued to dominate discussions about midwifery education and regulation throughout the next decade.[9–16] During this era, concerns were increasingly articulated about an ageing midwifery workforce and a projected shortfall in the numbers of midwives in Australia.[17] Furthermore, in line with international developments in midwifery, various Australian government documents identified the need for new midwifery models of care where midwives would provide continuity of care and practise according to the full role and sphere of practice of the midwife.[18–20] It was evident that there was a need to develop standards to ensure that midwives would be educated to fulfill such roles.

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Simultaneously, a growing number of midwifery leaders and academics were suggesting that a three-year undergraduate programme (BMid) should be considered in Australia, citing developments in midwifery education for initial qualification in other high-income countries, in particular the United Kingdom (UK) and New Zealand (NZ). In 1999, the Victorian branch of the Australian College of Midwives (ACM) published a booklet: *Reforming Midwifery: A Discussion Paper on the Introduction of Bachelor of Midwifery Programs into Victoria*[21] which made the case for the introduction of 'direct entry' programmes in Australia. This publication described how three-year programmes would enable graduates to develop and work in midwifery continuity of care models. It was significant in terms of raising awareness that the BMid was an initiative being proposed by Australian academics and practitioners in at least one state.

3. Resistance to the introduction of a three-year BMid in Australia

The notion of a collaborative effort – across Australian states and territories – to develop national standards for the introduction of BMid courses was first raised in 1999 in an article in the

A personal account of registering as a midwife in Australia in the late 1990s

As a midwife who entered the profession via the 'direct entry' route in the UK, I encountered many hurdles when attempting to register as a midwife in Australia in the late 1990s. My portfolio, demonstrating over 20 years of experience in midwifery, bulged with examples of practice, references and documents from the UK regulatory authority (UKCC). However, I was told that the Australian Nursing Council (the peak regulatory authority) did not recognise my qualification and I faced explanations from a series of officials that 'Australia needs midwives who are nurses – it's about safety'. I was refused registration in my home state, South Australia, and embarked upon the task of finding another state 'Nurses Board' that would register me, knowing that once registered in one state, the system of mutual recognition would allow me to practise midwifery in any other Australian state or territory, as well as in New Zealand.

Ironically, I was registered under the title of 'Registered Nurse (RN) and Certified Midwife (CM)' in New South Wales. On finally registering in South Australia, I was given a laminated A4 certificate stating that I was now a 'Registered Nurse Limited to Practise Midwifery'. Along with those who had been found guilty of professional misconduct or who were registered as being 'physically or mentally incapacitated', I was on the register of 'nurses with limited practising certificates'. This meant that I was not on the Board's mailing list, any correspondence to 'nurses with limited practising certificates' having to be passed in front of the Chief Executive Officer for approval through a process referred to as a 'screen dump'. I discovered this by accident when enquiring as to why I received no mail. My official protestations received a reply confirming this process but blaming it on the limitations of the Board's computer database. Apart from the emotional drain of all of this, I was at a loss to understand why the Nurses' Boards saw me as such a threat in their role to 'protect the public'.

Fig. 1. A personal account of registering as a midwife in Australia in the late 1990s.

Australian College of Midwives journal.[22] The article made the case for introducing BMid courses but highlighted examples of resistance to the notion of midwives who are not nurses, citing expressed concerns that midwives could only be safe practitioners if they were also nurses. Anecdotally, those of us who were starting to introduce the concept of a three year Bachelor of Midwifery were told repeatedly that the BMid would never happen in Australia due to the need to have dual-trained practitioners in rural communities. This opinion was expressed publicly by the State Secretary of the South Australian branch of the union for nurses and midwives, the Australian Nurses Federation (ANF). The article, entitled, 'ANF continues to oppose direct entry midwifery,' made a pledge to members:

> The ANF has a national policy, which opposes direct entry education for specialist areas of practice such as midwifery and mental health nursing . . .
>
> We believe that it is necessary for nurses to undertake a broad-based undergraduate program and to specialise at postgraduate level.
>
> This is particularly relevant in the contemporary environment where clients' needs are so diverse and nurses must be able, more than ever before, to respond to the full range of needs . . . direct entry midwifery courses are not in the best interests of the community or the nursing profession.[23, p.2]

The intensity of debate increased nationally with growing awareness that some universities were seriously considering introducing BMid programmes. The following quote from the Federal Secretary of the ANF provides a summary of some of the arguments and counter arguments in this heated debate:

> The ANF does not support direct entry midwifery programs. There are many arguments put forward in support of direct entry programs—that they are necessary to address the midwifery shortages; address deficiencies in current midwifery education; are necessary for the introduction of new models of midwifery care; are necessary in order to provide the highest quality maternity care; and, follow a world-wide trend in midwifery education . . . The ANF does not support the separation of midwifery into a separate profession. Nursing is a holistic profession, providing services to people of all ages, from conception to death. Birthing is a very special life event, but it is just one of many life events for women and families. It is not separate from, but part of the whole. To have a separate profession for birthing is as illogical as a separate profession to care for people who are dying, or a separate profession to care for people with mental health problems. Birthing should not be seen in isolation from the broader picture of women's health, sexual health, child and family health, or mental health, to name just a few.[24,p.1]

A personal account (NL) of registering as a 'direct entry' midwife at this time, offers an indication of the climate of hostility directed towards midwives who are not nurses (Fig. 1).

4. Developing the Australian BMid: a collaborative initiative

The development of a collaborative initiative to introduce and develop standards for the accreditation of Australian BMid programmes has been described fully by Pincombe et al.[25] The concept of such an approach was supported and encouraged by the Deans of both 'nursing' faculties in South Australia (Professor Judith Clare at Flinders University and Professor Annette Summers at the University of South Australia). Both universities were committed to starting a three-year Bachelor of Midwifery but, in a partnership approach, a decision was made to wait until other universities were ready to start courses at a similar time. It was thought that this would: maximise support for the students/new graduates; establish the BMid as a serious mainstream option with consistent standards; and prevent marginalisation of the courses in a potentially hostile climate.

There was also recognition that it was important to raise awareness of the issues that needed to be considered in preparing for the introduction of the BMid in order to potentiate its success and sustainability. The negotiations that led to this holding back exercise were complex and sensitive. They often took place in a competitive climate and a drive to be 'the first' university to start a BMid.

The South Australian universities employed a Project Officer, Jackie Kitschke, who coordinated a local working party and contacted universities across Australia in order to establish a register of interested parties. From this list, key people were invited to a two-day planning workshop in Adelaide in December 1999 with an aim to map the framework for three-year BMid programmes. Twenty people attended and a professional facilitator (funded by the SA Universities) skillfully enabled a consensus decision-making process as the group addressed the complexities of agreeing the components of a national framework for BMid programmes.

5. The Australian College of Midwives BMid Taskforce

A key outcome of the two-day workshop in Adelaide was a commitment from participants to set up a taskforce that would develop national standards for the accreditation of BMid programmes under the auspices of the Australian College of Midwives (ACM). Members of the inaugural ACM BMid Taskforce (Fig. 2) made a commitment to representing their states/territories and to ensuring that information concerning the BMid was both gathered and disseminated at a local level. This included holding public forums and engaging with universities, health services, regulatory bodies and consumers.

The Australian College of Midwives provided funding to extend the employment of Jackie Kitschke with a new role as the project officer for the ACM BMid Taskforce. Information was distributed widely through the 'BMid Newsletter' and through the journal of

The Australian College of Midwives Inaugural BMid Taskforce
Vanessa Owen (National ACM President)
Nicky Leap (Project Coordinator)
Jackie Kitschke (Project Officer)
Alana Street (ACMI Executive Officer)
Dianne Cutts (Victoria)
Jenny Browne (Australian Capital Territory)
Trish David (Tasmania)
Kathleen Fahy (Queensland)
Hilary Hunter (New South Wales) – later replacement: Lin Lock
Jan Pincombe (South Australia)
Carol Thorogood (Western Australia)
Bev Turnbull (Northern Territory)
Sally Tracy (Australian Midwifery Action Project)
Maree Markus (Advisor on Regulatory Issues)

Fig. 2. The Australian College of Midwives Inaugural BMid Taskforce.

the ACM.[26] In the interest of promoting an inclusive approach, an advertisement was placed in the ACMI Journal calling on universities to lodge expressions of interest regarding the introduction of a BMid. A database was set up to facilitate communication with all who expressed interest, including potential students of BMid courses. Attention was drawn to publications that would inform all key stakeholders about the initiative.[21,22,27,28]

The BMid Taskforce set up a National Reference Group to ensure that effective communication took place with key stakeholders, including regulatory bodies, employers, policy makers and research groups. Members of this reference group were invited to attend the bi-annual meetings of the BMid Taskforce.

An International Reference Group was also developed with a panel of midwifery education experts from the United Kingdom, New Zealand and Canada:

- Lesley Page (UK)
- Anne Thompson (UK)
- Sally Pairman (NZ)
- Anne Nixon (Canada, resident in Australia)

These midwifery leaders offered support for the introduction of a BMid in Australia. They shared their countries' experiences of developing similar programmes and had an ongoing role in reviewing the ACM Standards for the Accreditation of Bachelor of Midwifery Courses and related policy and curriculum documents.

Notably, the international reference group verified that the standards were compatible with international standards and that Australian graduates meeting these standards would be unlikely to have to engage in further education in order to register in their countries. In particular, the ACM standards met those in place in Europe in terms of minimum clinical practice requirements; they also incorporated the NZ requirement for students to have 'follow through' (continuity of care) experiences with individual women.[29]

This international reciprocity was an important issue when promoting and justifying the introduction of the Australian BMid: both in terms of a sense of professional pride, and the creation of opportunities for graduates to work overseas and return to Australia with useful experience. In spite of this advice, regulatory boards in Australia and some midwifery and nursing academics continued to express the opinion that they were opposed to developing reciprocity with other countries; they argued that Australian midwifery operated in a different context and therefore needed different standards. There were also concerns expressed about what was seen as Australian regulation being directed by other countries as well as concerns about the potential for graduates being encouraged to leave Australia.

6. The BMid Taskforce: using feminist process principles and consensus decision-making

Members of the BMid Taskforce made a commitment at the outset to consensus decision-making and feminist process. All meetings started with a 'round' where each member was assured of confidentiality and given space to talk about what was going on in her life – at home and at work – if she wanted. During this time, conscious efforts were adopted: to listen to each other; to avoid situations where any one individual dominated; and to respect different opinions while being open to persuasion. Agreed values and goals enabled this approach as well as extraordinary bursts of hard work and prolonged commitment to making change happen. The group made a conscious decision to engage in power sharing processes, described here by Cox[30]:

> The onus of responsibility can be legitimately shared in ways which give us credit for skills and recognise diversity without hierarchy. Sharing the burdens and responsibilities also means sharing the fun of being effective (p.256).

This quotation from Eva Cox sums up the success of the BMid Taskforce, where shared responsibility engendered a sense of fun in the relatively laborious tasks of pouring over every word of documents until consensus was achieved.

The process of consensus decision-making continued throughout the life of the BMid Taskforce, including during the circulating and re-circulating of all documents via the Internet for comment and editing. These email rounds continued until all parties were prepared to sign off on documents. In this way, the *ACMI Standards for the Accreditation of Three-year Bachelor of Midwifery Education Programs* document was developed. This was a highly challenging way of working for all, as some members reflected:

> At times, this process slowed things down, whilst lengthy discussions about language and context took place and differences of opinion were debated, but out of this arose a deeper and consensual understanding of what needed to be done, why, by whom and when.[25, p.27]

7. The Australian College of Midwives BMid Information Package

As well as developing the *ACMI Standards for the Accreditation of three-year Bachelor of Midwifery Education Programs*, the BMid Taskforce devised the *ACM BMid Information Package* in the form of a PowerPoint presentation with notes; this was presented in hard copy as well as on a CD. The presentation was based on one given to the Council of Deans of Nursing in 2000, outlining the international history of three-year programmes and the rationale for developing them in Australia.

The aim was for members of all branches of the ACM to give the presentation in as many venues as possible. The information package was designed to promote an extensive process of consultation with users and providers of maternity services, professional organisations and regulatory authorities. It was proposed that this process of consultation and information sharing would help engender support for student placements and assist in the process of registering and employing graduates of BMid courses.

The rationale for the introduction of an Australian Bachelor of Midwifery (BMid) was presented in the information package as part of the overall aim of the ACM to increase the number of competent midwives and midwifery graduates in all areas of Australia, the introduction stating: 'the bottom line for any developments has to be improvements to the services offered to childbearing women, their families and communities'. The information package made an appeal to key stakeholders around the following themes:

- The need to develop national standards for midwifery education embedded in regulation
- The identification of midwifery as a discreet profession in its own right, separate from nursing
- Addressing midwifery workforce shortages
- Appropriate education to enable midwives to work in continuity of care models according to the international definition of the midwife
- International trends and evaluations in midwifery education and the need to ensure compatibility of standards
- The disadvantages Australian midwives face in having to complete further studies or practice when seeking to register in other Western countries.

Identified concerns and misconceptions about the BMid were also addressed in the *ACM BMid Information Package*. The PowerPoint slides and notes reflected the arguments that had been developed through the extensive discussion and consensus decision-making that had taken place in the ACM BMid Taskforce.

Around the same time as the information package was being developed, funding of a major research project to study Australian midwifery was announced. The Australian Midwifery Action Project (AMAP) would fully explore and examine all of the issues at stake and would provide evidence to inform ongoing debates surrounding the introduction of the Australian Bachelor of Midwifery.

8. The Australian Midwifery Action Project

In 1997, a group of midwifery educators, practitioners and researchers had met in Melbourne to share their concerns about standards of education and practice and the limited range of midwifery continuity of care services available to women. Subsequent meetings with the maternity services advocacy group 'Maternity Coalition' and the organisation 'Women's Hospitals Australasia', reinforced these concerns. A plan was agreed to develop a proposal for funding of a major national study about midwifery and the role of midwives in Australia. This proposal brought together researchers from the fields of midwifery, nursing and sociology along with five separate industry partners: The Australian College of Midwives; Women's Hospitals Australasia; South East Sydney Area Health Service; South Australian Department of Human Services and New South Wales Health Department.

Led by Professor Lesley Barclay, the Australian Midwifery Action Project (AMAP) was funded by the Commonwealth Government of Australia through the Australian Research Council as part of the 'Strategic Partnerships with Industry Research and Training' (SPIRT) program. A three-year project, AMAP was set up in April 1999 with a goal to provide information to assist industry partners, health departments, health services, universities, policy makers and regulatory bodies to improve maternity care. The project analysed the barriers to safe and cost-effective midwifery care and examined the problems of communication and co-ordination across these sectors.[1,2]

9. AMAP—research involving collective action

The AMAP research team worked as a group rather than accepting that one 'best person' has sufficient knowledge or is free from personal or professional idiosyncrasy. Findings from the empirical data generated by AMAP were thus integrated with the varied and different opinions, backgrounds and experiences of all the researchers and their industry partners. This process has been described as 'synthesising judgement'; a necessary step in making high quality decisions in the absence of certainty and evidence from randomised controlled trials.[31]

As its name suggests, the AMAP project was deliberately action oriented: it was about engaging in activities to create change as well as generating information and 'mapping' key areas of concern. This research approach is explained in Volume One of the AMAP Report[1, pp.17–28] and is supported by literature showing that collective action is an important process for building reputation, reciprocity and trust[32] and sustainable change in institutions and organisations.[33–35]

The findings of the AMAP study revealed significant concerns related to midwifery education, regulation and policy, highlighting the invisibility of midwifery within nursing and the barriers to midwives fulfilling their potential role and scope of practice.

9.1. AMAP: addressing workforce issues and midwifery education

One of the first papers to emerge from the AMAP research was published in the *Australian Health Review*.[36] Entitled 'Contemporary issues in the workforce and education of Australian Midwives' it drew on multiple data sources in a mapping exercise to identify issues related to the workforce and education of Australian midwives. The study confirmed concerns raised by an Australian Medical Workforce Advisory Committee (AMWAC) report, which found that no comprehensive data was available on the workforce of practising midwives.[37] Where data was available, it demonstrated a shortage of midwives, particularly Indigenous midwives and midwives in rural and remote areas. Consideration of a BMid was proposed to address the high cost to students and universities of educating midwives through postgraduate programmes following three-year undergraduate programmes in nursing.

This paper was the first in a series that provided accurate documentation that there was no overall consistency in design, duration or level of award for midwifery education programmes, both nationally, and within each separate state and territory jurisdiction. The lack of a monitoring system to guarantee comparability or an adequate baseline of competence was also identified.

These findings were reinforced in an AMAP study involving a telephone survey. Course coordinators in each university providing a program for qualified nurses wishing to become midwives provided information about their courses, including length, curriculum content and perceived issues and challenges.[38–40]

The AMAP Education survey revealed that full time courses ranged from 9 to 12 months over two 13–14 week university semesters. Most courses had fewer than 400 h of theory and fewer than 1000 h of clinical practice requirements, with little, if any, community based placements. In some states there were no minimum practice requirements in courses, with examples of students being signed off as competent to practise on qualification, having attended fewer than five births. Problems were identified where nurses were fitting full time study and midwifery clinical placements around continued full time employment as a nurse.[38] Course coordinators described difficulties in securing appropriate clinical placements with poor communication between hospital and university staff.[39] Attrition rates from courses were high in many universities and a quarter of graduates were not employed in midwifery on graduation due to insufficient employment opportunities.[40]

9.2. AMAP: addressing the barriers to midwifery

The AMAP project gave evidence to Senate Inquiries, policy makers and professional organisations, and engaged in extensive consultations with consumer organisations and leaders of maternity services. The research midwives (PB and ST) participated in national tours and conferences over a two-year period and used graffiti boards – anonymous surveys – and an interactive website to enable midwives from different settings to describe what they saw as the barriers to midwifery.[41,42] Many of the comments posted by midwives expressed concerns about the skills of new graduates, the quality of clinical placements for students and the lack of exposure to situations involving midwifery continuity of care in midwifery education programmes.

9.3. AMAP: addressing the invisibility of midwifery

The AMAP project identified that, where nursing sees fit to lead policy recommendations on behalf of midwifery and where midwifery is neither fully included nor presumed to require its

own arena and platforms, important issues need to be raised concerning power and control. The exclusion of midwifery nomenclature was seen to render midwifery invisible within nursing and this had particular implications for the development of policy, regulation and standards that protect the public.[43]

10. Review of midwifery education for the National Inquiry into Nursing Education

During the life of AMAP, a review of midwifery education was commissioned by the Department of Education, Science and Training (DEST), as part of a *National Inquiry into Nursing Education*. The review included the preliminary findings of the AMAP Education Survey and an extensive literature search drawing on databases, policy documents, research and other resources, in collaboration and with assistance from national and international experts.[44]

A focused literature search on midwifery education in the UK, Canada, New Zealand, Netherlands and the USA was undertaken. The researchers' private collections of relevant documentation, much of which was gathered during educational visits to these countries, also informed the initial search. Midwifery education experts from each country were identified through professional networks, several of them having also provided information and advice to the ACM Bachelor of Midwifery Taskforce. The contributors were Tina Heptinstall (UK); Anne Nixon (Canada); Beatrijs Smulders (the Netherlands); Sally Pairman (New Zealand); and Holly Powell Kennedy (USA).

These international experts were informed of the purposes of the Review, and were invited to comment on an initial draft of an overview of midwifery education and development in their country. They were asked to confirm that key issues relating to midwifery development and education in their country were adequately and accurately addressed and to identify any sources of unpublished literature or literature that had not been accessed in the initial search. The international experts were asked to address the themes identified by DEST for the Review, in particular issues relating to standards for midwifery education and the development of these in each of their countries. Their modification of the documents enabled international comparisons to be made.

The review of midwifery education identified that a 'levels of evidence' approach to assessing the quality of literature presumes 'objectivity' that is only possible in the presence of high quality empirical data. As in health care itself, there are many areas where sufficient research based evidence does not exist. According to Black et al.,[31] in such situations it is appropriate to draw on the opinions and experience of those with knowledge of the subject at issue. The researchers made the case for a synthesis of empirically derived data and consensus development derived from expert opinion. Those who contributed to the review were recognised as 'experts' by the professional community in Australia and in a number of other countries by bodies such as the World Health Organization, national and state governments, and international midwifery associations.

The comprehensive literature review of midwifery education and the recommendations pertaining to midwifery provided to the *National Inquiry into Nursing Education* were not included in the final report of the Inquiry. The AMAP researchers made formal requests for inclusivity following release of the draft report, but these were ignored. All recommendations in the final report referred only to 'nursing' and 'nurses' and the recommendations from the midwifery literature review were ignored; the commissioned literature review remained invisible in the final report of the Inquiry. An informal conversation with one of the key organisers of the Inquiry identified that, in the consultation process that took place around Australia, nurses expressed contradictory points of view about midwifery from those in our review, particularly regarding the development of the BMid and that therefore our contribution had not been included in the final report.

11. National standards for the accreditation of all midwifery education programmes

Highlighting the growing number of midwives who were not nurses, an AMAP paper was influential in reforms leading to the regulation of midwifery as a separate profession from nursing.[43] The authors made the case for a regulatory framework that clearly identifies midwifery and the appropriate education of the profession in order for the midwifery care offered to Australian women to be comparable to that offered in other Western countries.

Bolstered by the evidence from the AMAP research, in the early 2000s, the ACM began a concerted effort to develop an integrated set of standards for the profession of midwifery and to form partnerships with some key nursing organisations. It was envisaged that such collaborations and changes in nomenclature would enable a shift of power and control away from nursing so that these standards could be governed by the ACM.[43] Although the ACM did not become the regulatory body for midwifery, in 2004, the peak body for state and territory 'nursing' regulatory authorities changed its name to the Australian Nursing and Midwifery Council. Over the next decade, separate systems were set up for the regulation of midwifery; nomenclature that reflected midwifery as a separate profession to nursing began to appear in all institutions and policy documents related to midwifery education, regulation and practice.

In 2003, the ACM BMid Taskforce was disbanded and a democratic selection process took place to enable representation from each state and territory in a new taskforce: the ACM National Standards and Education Taskforce (ANEST). This group developed a framework of standards and position statements for the ACM using the same consensus building techniques as those employed previously by the ACM BMid Taskforce.

Within a climate of increasing solidarity in Australian midwifery following the AMAP research, concerns were raised in some quarters that many Australian midwives and nurses were embracing the 4-year Double Degree in Nursing and Midwifery as the ideal solution for the Australian context. Information gathered through informal networks, the ACM and the BMid Taskforce suggested that universities were encouraging their staff to develop the double degree in preference to the BMid.

A strong argument was developed to support an opposing view: one that advocated strongly for the BMid as a more appropriate alternative. The Centre for Midwifery and Family Health at the University of Technology produced a monograph to promote discussion at an ACM Education Forum. Evidence from national and international research, policy documents, the National Maternity Action Plan developed by consumers[45] and the opinions of midwifery experts were synthesised within the monograph. A case was made that the BMid was the most appropriate course to address the need for widespread, publicly funded, community based, midwifery continuity of carer.

The monograph included a summary of the arguments in favour of a Double Degree in Nursing and Midwifery as well as opposing positions. Questions were posed that invited responses from midwives, with an assumption that all midwives would support the notions of international compatibility, midwifery models of care and a strong midwifery (as opposed to nursing) identity. Respect was paid to those who work in both roles in rural and remote areas but the emphasis was on exemplary education

systems and standards in both professions. This monograph subsequently informed an ACM Position Paper.

One of the first crises that the new ACM National Education and Standards Taskforce (ANEST) had to negotiate was a heated debate regarding the ACM Position Paper that stated the College's opposition to the notion of a double degree in nursing and midwifery. This position paper was challenged as divisive and unwise through a motion at the 2003 Annual General Meeting of the ACM. The motion was unsuccessful but a commitment was made to re-write the statement on midwifery education.

In the interest of supporting all midwifery students, and amidst assurances that the graduates of double degree programmes would meet the *ACMI Standards for the Accreditation of three-year BMid* Programs, the new ANEST group initiated discussions to consider a more open positioning about the double degree. A major shift in thinking developed during meetings and email conversations throughout 2003 and the first half of 2004. The *ACMI Standards for the Accreditation of three-year BMid Programs* were finally adopted as the *ACMI Education Standards for Midwifery Education* with an aim for these to be the standards of all programmes leading to initial license to practise midwifery in the future, regardless of routes of entry to the profession. The tone of the new position paper was one of inclusivity with the setting of standards acting as a leveller.[46] The position paper highlighted the range of documents that the ACM had developed in its '*ACMI Framework for Midwifery*':

ACMI Position Paper: Midwifery Education (2004)

The ACMI* recognizes multiple routes of entry into midwifery and values graduates from all programs. The ACMI strongly supports the establishment of undergraduate midwifery programs. The ACMI recognizes that midwifery and nursing are distinct professions each with its own philosophy, ethics, body of knowledge and scope of practice.

The discrete and independent nature of the profession of midwifery is fundamental to all curricula that lead to registration as a midwife. Midwifery curricula must enable students to acquire the knowledge, skills and attitudes necessary to practise to the full role and scope of midwifery as defined by the ICM/FIGO/WHO (1992). Programs of midwifery education must therefore reinforce and promote the recognition of midwifery as a separate professional identity.

The theoretical and clinical practice components of all midwifery programs are underpinned by the *ACMI Framework for Midwifery*, which incorporates the:

ACMI Midwifery Philosophy
ACMI National Code of Ethics
ACMI National Standards for Midwifery Practice
ACMI National Midwifery Competencies
ACMI National Midwifery Guidelines for Consultation and Referral
ACMI Standards for Midwifery Education
ACMI Framework for Continuing Professional Development

The ACMI is committed to collaborating with regulatory authorities on the accreditation of all midwifery education programs conducted in Australia.

The ACMI promotes and expects all midwives as part of their professional obligations to engage in regular, relevant and high quality ongoing education and practice, supported by the *ACMI Framework for Continuing Professional Development*.

*At this time the ACM was still using the title Australian College of Midwives Incorporated (ACMI)

This position paper identifying the *ACMI Framework for Midwifery* (2004) provides a suitable place to conclude the story we have told. Whilst midwifery in Australia still does not have a separate regulatory board, in ensuing years, modifications of the documents developed by the ACM have been incorporated into all regulation relating to midwifery. Midwifery committees, with representation from the ACM, are responsible for developing standards for midwifery in all state and national authorities. This includes national standards for the accreditation of all midwifery education programmes.

12. Conclusion

The process of arguing for and commencing the development of national standards for midwifery education in Australia can be seen as one of collective action. This involved the positioning of midwifery as a separate profession from nursing, with a need for its own discreet regulation.

We are aware that midwives in many countries around the world continue to face challenges associated with midwifery's invisibility within nursing and inadequate educations standards, as identified in a World Health Organization (WHO) report (2016).[47] In a large global survey of 2470 midwives in 93 countries 89% of respondents reported that a clear understanding of midwifery is vital to overcome professional barriers, such as the devaluing of midwifery and the medicalisation of childbirth. In order to overcome these barriers, key recommendations of the WHO survey were the need to identify midwifery as a separate profession from nursing and the importance of strengthening midwifery education and regulation.

In conclusion, we pay tribute to the work of our friend, colleague and doctoral supervisor, Professor Lesley Barclay. As has been shown in this paper, her commitment to improving midwifery education in Australia has spanned four decades and is a fine example of bringing people together for collective action in order to change minds and systems. She has led research and policy reform that continues to influence efforts to provide quality midwifery care for women and families in Australia.

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