Educating Australian midwives: current debates and concerns

Nicky Leap RM, MSc.

Abstract

This discussion paper highlights current debates concerning the appropriate way(s) to educate Australian midwives so that they are confident and competent to work according to the full potential of the midwife's role. International comparisons are made when considering programs for nurses who wish to become midwives as well as the new midwifery education programs being introduced to Australia: the three year Bachelor of Midwifery and the four year Double Degree in Nursing and Midwifery.

Introduction

In the last decade, new models of maternity care have been developed in Australia and overseas in response to changes in government policies and the identification of strategies to better meet the needs of childbearing women (Tracy et al 2000, NHMRC 1999). According to Page (1997:5), 'the basis of these reforms in all countries is the provision of appropriate education and preparation for modern day midwifery practice'. In Australia, as elsewhere, midwives are licensed so they must be prepared at a level that enables them to function as practitioners in their own right on graduation, without having to undertake further education or training. This means that graduates of midwifery education programs should be capable of taking responsibility for the total care of a woman (and her baby) throughout the woman's pregnancy, labour and birth, and the early postnatal period, referring to other health professionals only when complications arise. This paper explores some of the issues associated with preparing midwives for this role and draws on the midwifery education survey carried out by the Australian Midwifery Action Project (AMAP 2002).

New midwifery models in Australia

The 'New Models of Maternity Service Provision: Australian Midwifery Perspectives' conference held in 1998 in Adelaide could be seen as a turning point in contemporary Australian midwifery development. Hosted by the Women's and Children's Hospital and Flinders University, Adelaide, the conference brought together midwives from across Australia to showcase the innovative projects that were offering women midwifery continuity of care. Several of these had been established for a few years as a result of the Commonwealth Alternative Birthing Services funding but the majority of projects were in their infancy. The atmosphere at this conference was one of highly charged expectation. It seemed as though Australian midwifery was on the brink of fundamental changes and that the recommendations of government documents, such as the 1996 NHMRC *Options for Effective Care in Pregnancy and Childbirth*, would be implemented.

In the last five years, progress has been slow but midwifery models including team midwifery and caseload practice have continued to be developed in Australia. Recently, organised consumer demand for midwifery continuity of care has been articulated in *The National Maternity Action Plan* (NMAP 2002) and in campaigns to replicate the

successful midwifery run free-standing birth centres of other countries (Rooks et al 1992; Waldenstrom et al 1997; Saunders et al, 2000), particularly in areas where small maternity units are facing closure.

In light of such changes, many midwives have been considering how best to prepare midwives for the full potential of their role. Where midwives provide continuity of care, they 'follow' individual women across the interface between hospital and community services. They need to work in a different role from midwives who work in one area of hospital based maternity service provision - such as antenatal clinic, delivery suite, birth centre, postnatal ward or early discharge program – often referred to as providing 'fragmented care'.

Midwifery education in other countries

In other comparable western countries, midwifery is seen as a distinct profession, with its own discreet body of knowledge, and not as a specialisation of nursing. Most midwives graduate from three and four year 'direct entry'[1] (DEM) programs. The minimum length of courses for qualified nurses wishing to become midwives is 18 months. However, there is a move towards nurses undertaking at least two years of the three and four year DEM education programs in order for them to gain sufficient experience of midwifery practice (UKCC 1999, correspondence with midwifery educators in NZ).

European countries such as France, Germany, Denmark, Belgium, Switzerland and the Netherlands have continued to develop three and four-year programs as the only route of entry to midwifery ever since midwifery was regulated in those countries during previous centuries. In New Zealand (NZ) and Canada, the development of DEM education programs was chosen following legislation that enabled autonomous, publicly funded midwifery services (Tulley 1999, Tyson 2001). As in the United Kingdom (UK), - where over 80% of midwives are now educated through three and four year programs - DEM education was developed in NZ and Canada following research identifying this as the most appropriate way to prepare midwives for their full potential role (Radford and Thompson 1988, Tulley 1999, TFIMO 1987). Rigorous evaluations of DEM education programs in other countries have been encouraging, particularly in terms of recruitment and the education of competent, confident midwives, capable of providing continuity of care in all settings on completion of study (Kent et al 1994, Fraser et al 1998, New Zealand Ministry of Health 1995, Kaufman et al 2001a, 2001b).

[1] In order to make international comparisons, the term 'direct entry' midwifery (DEM) will be used here. Australian midwives prefer to refer to a 'Bachelor of Midwifery' (ACMI Victoria). Since this is not necessarily a recognised term for courses for initial authorisation to practise midwifery in other countries (for example, many of the programs in the UK are Diploma courses) the term DEM will be used to avoid confusion whenever it applies to other countries.

Wherever governments enable women to have publicly funded continuity of midwifery care, DEM education is regarded as the most appropriate form of education for midwives. This is because it allows at least three years of concentration on midwifery theory and practice in equal proportions and enough time for students to gain plenty of experience of midwifery in both hospital and community settings. Study of at least three years duration is seen as the way to prepare graduates who, on point of entry to the profession, are safe, autonomous primary care providers.

In these countries, there is a move towards competency-based assessment and the opportunity for student midwives to have their own (supervised) caseload of women for whom they provide continuity of care in the final year of study. However, there are still minimum practice requirements in programs, including the need for students to attend at least forty births, in order to reach competency. By comparison, the maximum number of births that Australian midwifery students are required to participate in is twenty. Brodie and Barclay (2001: 106) point out that all current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries. They point out that in the UK Canada and NZ, regulatory boards use agreed national criteria to accredit, not only curricula, but also teachers, facilities and services. In these countries regulatory frameworks ensure that theory and practice are integrated in equal proportions in programs and that adequate staff to student ratios are maintained in clinical areas.

Australian midwifery education for qualified nurses

With two exceptions[2], all midwifery education programs for nurses who wish to enter midwifery are at postgraduate level, either in the form of a Graduate Diploma, or, in three cases, as a Masters degree. This is in keeping with other postgraduate programs for nurses since midwifery is presumed to be a specialist area of nursing in regulation (Brodie & Barclay 2001). The AMAP Education Survey (AMAP 2002) revealed that courses for nurses undertaking full time midwifery education in Australia varied in length from two academic semesters of approximately fourteen weeks each, to one calendar year. However, financial pressures meant that almost two-thirds of students undertook midwifery education part time, and continued to work as nurses throughout this process. Courses varied considerably in terms of the amounts and ratios of midwifery theory and practice hours[3] and high attrition rates on graduation were reported. One year 'Graduate Midwifery Programs' in some states and territories provide extra education and address the fact that graduates do not emerge from programs as confident, competent practitioners.

In midwifery circles there has been increasing unease about the fact that Australian nurses who wish to become midwives meet lower standards and undertake a significantly

[2] Two South Australian universities offer midwifery education for nurses through a one year Bachelor of Midwifery.

[3] The AMAP Educational Survey reported that, according to midwifery course coordinators, the theory component of courses ranged from 174 – 400 hours in the majority of courses (up to 2,160 theory in external courses). Midwifery practice hours ranged from 500 – 1824 with the majority being less than 1000 hours.

shorter midwifery education program than nurses in other western countries. The notion of midwives graduating from specialist nursing courses (some at Masters level) as 'beginning level midwifery practitioners' (Glover 1999) is at odds with the international view that midwives should graduate capable of 'hanging up their shingle' from day one of qualification. Furthermore, since Australian midwifery education programs for nurses are so much shorter than those of other countries, involving little, if any, community experience (AMAP 2002), Australian midwives currently have to undertake further education if they wish to register to practise as midwives overseas.

The introduction of the Australian Three Year Bachelor of Midwifery

Increasingly in Australia, the case has been made for a three year Bachelor of Midwifery (Hancock 1992, ACMI Victoria 1999, Leap 1999, Owen 2000, ACMI 2002). The rationale for the introduction of an Australian Bachelor of Midwifery (BMid) has been explored by the Australian College of Midwives Incorporated (ACMI) in terms of the College's overall aim to increase the number of competent midwives and midwifery graduates in all areas of Australia. According to the ACMI, 'the bottom line for any developments has to be improvements to the services offered to childbearing women, their families and communities' (*ACMI BMid Information Pack*).

In 2002, over 150 students commenced study in a three-year BMid in four universities in South Australia and Victoria. As in other countries, competition for places in these courses was extremely keen. At least four other universities in New South Wales, ACT and Victoria are planning to start a three-year BMid in 2003.

The ACMI has played a major role in the development of the three year BMid through coordinating the ACMI BMid Taskforce. This group, representing midwifery educators from each state and territory, has developed national standards for the accreditation of three-year BMid programs and hopes to work collaboratively with the registering authorities in the future regarding the implementation and evaluation of these standards. An advisory panel of international midwifery education experts was identified, all of whom have offered support for the introduction of a BMid in Australia. They have shared their countries' experiences of developing similar programs and will have an ongoing role in reviewing the ACMI Standards for the Accreditation of three year Bachelor of Midwifery Courses (ACMI 2002) and related standards and curriculum documents. The ACMI BMid Taskforce has a commitment to ensuring international compatibility so that graduates of the Australian BMid courses will be able to register to practise in other countries without having to undergo further training and education.

The Australian Double Degree in Nursing and Midwifery

In 2002 in one Australian university a double degree in Nursing and Midwifery was commenced. This double degree program integrates both nursing and midwifery throughout a four year program. At least one other university is planning a four year double degree with a different format - three years of nursing followed by one year of specialisation in midwifery. Supporters of this plan argue that, in effect, this reflects the current situation in Australia where graduates of three year nursing degree programs are able to enter a one year post-graduate diploma in midwifery, often without having had to practise as a nurse first. The only difference, they claim, is that graduates will qualify in

midwifery at Bachelor level. In personal communications with two midwifery educators who do not wish to be named, the following arguments supporting the double degree (as opposed to the three year BMid) have been put forward:

- The workforce crisis, particularly difficulties in recruitment in both midwifery and nursing, is addressed by a double degree since the course is very popular, particularly with school leavers.
- Any strategy that enables the current quota of midwifery student places to be filled in a situation where courses are threatened with closure due to low enrolments must be tried in those Schools of Nursing who have decided not to support the three year BMid.
- Nursing's authority in university Schools of Nursing and at Nurses Board level will enable successful course approval and implementation of the double degree which is seen as more politically acceptable to nursing leaders (who see midwifery as a specialisation of nursing) than the three year BMid.
- Australia has different needs from other countries in that rural and remote communities need dual educated nurse-midwives.
- The standards being proposed by the ACMI for the three year Bachelor of Midwifery are unrealistic and cannot be met in Australia, whereas the double degree will meet existing accreditation standards.

Discussion

The arguments presented here in support of the double degree are justifiable in terms of maintaining the status quo of Australian midwifery as a specialisation of nursing. A one year midwifery program, either following a nursing degree program or integrated within a double degree will perpetuate a situation where Australian midwifery graduates are being prepared to meet different standards from midwifery graduates in all other comparable western countries.

Rather than viewing midwifery as a specialisation of nursing, the ACMI articulates midwifery as a discipline in its own right with a discreet, well defined sphere of practice; the professional body for Australian midwifery therefore does not support the existing or proposed double degrees in nursing and midwifery (correspondence with ACMI Executive Officer, 2002). The ACMI has concerns that midwifery students are in danger of being locked into courses that are internationally incompatible, that do not allow enough concentrated time for students to gain the experience they need to become practitioners in their own right, able to cross the interface between hospital and community settings in the new models of care proposed in government documents and demanded by consumers. There are also concerns that students will not develop enough theoretical understanding of midwifery, even where double degrees may allow midwifery to eat into more than a year's worth of a three year nursing degree within a four year program. It may be worth considering that double degrees in other subjects, for example Accountancy and Law, prepare students over five years in order for them to gain appropriate knowledge in two professions. In not recognising nursing and midwifery as separate disciplines, Australian midwifery may be at risk of short-changing students and ultimately the services offered to the public by both professions.

It is accepted throughout the world that when a nurse graduates from a three year degree program, s/he has to undertake further education, whether formal or informal, in order to specialise in an area of nursing. This is not the case for midwifery, which licenses midwives to practise from day one of graduation according to the full sphere of practice described in the *International Definition of a Midwife* (ICM 19XX). Questions must be asked as to how graduates of four year double degree programs are going to be able to practise in rural and remote areas as nurses and midwives without considerable further education in both disciplines, particularly in areas where access to tertiary care is limited and practitioner skills are required. Midwives educated through three year BMid courses who wish to work in any job that requires a dual role in both midwifery and nursing will be competent to fulfill the midwifery (practitioner) aspect of the role, but will expect to undertake further education in nursing. In some cases this will mean a Bachelor of Nursing. This is not unreasonable if quality services are to be maintained in rural and remote areas. However, midwifery models of care are not urban phenomena and Australia is not unique in its geographical proportions. In many rural and remote areas, both in Australia and elsewhere, examples are emerging of the re-organisation of maternity services in ways that do not require midwives to work as nurses. This can have far reaching consequences for women as demonstrated in the far northern reaches of Canada, where remarkable improvements in outcomes for Indigenous mothers and babies have been achieved through collaborative midwifery projects (Tyson 2001).

The standards proposed by the ACMI for the three year BMid are standards that should inspire confidence in midwifery graduates. There is a strong argument that any midwifery education program should meet these standards. Some would argue though that Australian maternity services should not be compared to other countries; that Australian women do not necessarily want continuity of care from midwives; that they prefer to get this service from private obstetricians or from their general practitioner. Research carried out by Zadoroznyj (2000) and Homer et al (2000) refutes this notion in demonstrating that many women do not ask for midwifery care because they have no way of understanding the concept until they experience it since information about midwifery-led care is not widely available. Once exposed to midwifery care, women in these studies were extremely positive about midwifery care and the majority indicated that this is what they would choose in subsequent pregnancies. It is worth bearing in mind that in NZ, where ten years ago government funding enabled women to choose a primary caregiver, the majority – over 75% - of women now choose midwives.

In other comparable western countries, midwifery is being promoted as a public health strategy to address health inequalities (RCM 2000a, 2000b, Garrod 2002). Currently, the potential for students in Australian midwifery courses to gain experience in this role is limited with eleven courses not providing students with placements in any areas other than hospital wards (AMAP 2002). The AMAP Education Survey identified that ‘community placements’ in some other courses included ‘a reproductive medicine unit’, ‘medical practitioner’s rooms’, ‘a birth centre’ or ‘an elective in a rural hospital’. Clearly, any placement other than a hospital ward is being defined as ‘community’ making it hard for students to gain any understanding of primary health care principles in action. Instead, Australian midwives are being educated for an acute care role in the majority of courses

and are not exposed to experiences that might foster an understanding of their potential role as primary care providers based in the community and the difference of this role from that adopted as a midwife (or nurse) in a hospital team.

The fact that the indemnity insurance crisis is currently limiting midwifery students' practice placements to hospital settings is a further cause for concern. If students are unable to follow women through their experience of childbirth by visiting them in their homes, particularly in the early weeks after birth, the standards set by the ACMI and certain regulatory authorities will not be reached; students will be educated for a limited role in hospital practice that does not include providing continuity of care to women. Furthermore, the increasing use of technology in childbirth and escalating caesarean section rates limit the opportunity for students to learn about normal childbirth (Davies 1996, Hunt 2000). These concerns have been explored by Barnes (1997), who describes Australian midwifery students struggling to develop a 'woman centred' approach to care in the light of the increasing medicalisation of childbirth, in particular, rising epidural and caesarian section rates.

Recruitment to DEM education programs in other countries has continued to be highly competitive, attracting both mature age students and school leavers. It is likely that the same will be true for both the Australian BMid and the double degrees in nursing and midwifery. As with the current one year programs for nurses, as long as there are no national standards for midwifery education, graduates emerging from programs will vary considerably in terms of the levels of competence and experience they have been required to meet by state and territory nurses boards. If Australia is to continue to have widely disparate models of midwifery education, decisions have to be made as to whether programs should meet the same standards or whether the present system, where some midwives graduate having had drastically reduced midwifery practice opportunities, is acceptable.

Conclusion

As demonstrated in this paper, many questions need to be answered in terms of the standard and type of services midwives will be able to offer to Australian women in the future. It will remain to be seen whether graduates of the new programs will be confident, competent practitioners; whether graduates from double degrees will choose to work primarily in nursing or in midwifery; or whether graduates from any programs will choose to work in dual roles. What is required urgently is Commonwealth funding to evaluate all models of midwifery education and to investigate whether the current standards are appropriate to enable Australian midwives to provide safe, collaborative care within the proposed new models of maternity service provision that place women at the centre of care. It is timely for the regulatory authorities to liaise with the ACMI so that the professional organisation representing midwives is centrally involved in setting and maintaining national standards for midwifery education and practice.

References

ACMI. (2002*). Draft Standards for the Accreditation of three year Bachelor of Midwifery education programs*. ACMI. Melbourne.

ACMI. (1998). *ACMI Competency Standards for Midwives.* Melbourne: ACMI. Melbourne.

ACMI Victoria. (1999). *Reforming Midwifery: A discussion paper on the introduction of Bachelor of Midwifery programs into Victoria*. Victoria: ACMI - Victorian Branch.

AMAP. (2002).Mapping Midwifery Education in Australia: full findings of the AMAP Education Survey. *AMAP Final Report*. Volume II. Centre for Family Health and Midwifery, University of Technology, Sydney.

Barnes, M. (1997). Student Voices: reflections on professional and practice issues in midwifery. *Birth Issues*, 6, 9-15.

Brodie, P. & Barclay, L. (2001). Contemporary issues in Australian Midwifery Regulation. *Australian Health Review*. Vol 24 (4). 113-118

Davies, S. (1996). Divided loyalties: the problem of 'normality'. British Journal of Midwifery, 4, 285-286.

Garrod, D. (2002) Sure Start: The role of the public health midwife. *MIDIRS Midwifery Digest* (12) supplement 1:S32-S35

Glover, P. (1999). The midwifery curriculum - preparing beginning or advanced practitioners? ACMI Journal, 12, 1, 19-24.

Hancock, H. (1992). Midwifery Education: whither will be wander? *ACMI Journal*, 5, 26-29.

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

Hunt, S. (2000). A student's experience of normal birth. *Midwifery Matters*, 86, 6.

ICM 19XX *Definition of a Midwife.*

Kaufman, K., Pong, R., Hogenbirk, J., Martin, L. (2001) Midwifery care in Ontario: Client outcomes in 1998. Part 1: Maternal outcomes. *Association of Ontario Midwives Journal* 7(2):56-64

Kaufman, K., Pong, R., Hogenbirk, J., Martin, L. (2001) Midwifery care in Ontario: Client outcomes in 1998. Part 2: Fetal and infant outcomes. *Association of Ontario Midwives Journal* 7(4):147-153

Leap, N. (1999). The Introduction of 'Direct Entry' Midwifery Courses in Australian Universities: issues, myths and a need for collaboration *ACMI Journal*, 12, 11-16.

Leap, N. & Barclay, L. (2002). Midwifery Education: Literature Review and Additional Material. *National Review of Nursing Education*. DEST publications.
http://www.dest.gov.au/highered/nursing/pubs/midwifery/1.htm

New Zealand Ministry of Health. (1995). *Evaluation of direct entry midwifery programs. 2nd Interim Report.* Wellington. Government Printer.

NHMRC (1996) NHMRC *Options for Effective Care in Pregnancy and Childbirth.* Canberra: National Health and Medical Research Council.

NHMRC. (1999). *Review of services offered by midwives*. Canberra: National Health and Medical Research Council.

NMAP (2002) *National Maternity Action Plan for the introduction of Community Midwifery Services in Urban and Regional Australia.* Canberra. Maternity Coalition.

NSW Department of Health. (2000b). *Report on the New Graduate Midwives Survey* Nursing Branch, NSW Health.

Page, L. (1995). *Effective group practice in Midwifery: Working with women*. Oxford: Blackwell Science.

Page, L. (1997). Impressions of midwifery in New Zealand and Australia. *Birth Issues*, 5, 5-7.

Radford, N. & Thompson, A. (1988*). Direct Entry: A Preparation for Midwifery Practice.* Surrey: University of Surrey.

RCM, (2000a). *Midwives in the new NHS. Paper 4: Public Health.* London: Royal College of Midwives.

RCM, (2000b). *Vision 2000*. London: Royal College of Midwives.

Rooks, J, Weatherby, N, & Ernst, E. (1992). *The National Birth Centre Study: Part 11*. Intrapartum and immediate postpartum and neonatal care. *Journal of Nurse Midwifery.* 37 (5). 301-330.

Saunders, D., Boulton, M., Chapple, J et al. (2000). *Evaluation of the Edgware Birth Centre.* London. Barnet Health Authority.

TFIMO (1987) *Taskforce on the Implementation of Midwifery in Ontario Report.* Toronto. Government publications.

Tracy, S., Barclay, L. & Brodie, P. (2000). Contemporary issues in the workforce and education of Australian midwives. *Australian Health Review*.23. 78-88.
Tyson, H. (2001). *The Re-emergency of Canadian Midwifery: A New Profession Dedicated to Normal Birth.* Presented at Future Birth: Keeping Birth Normal! Conference, Australia, Transcript available from Birth International, Sydney. In.
UKCC. (1999). *Fitness for Practice* London: UKCC.
Waldenstrom, U & Nilsson, C. (1997). A randomized controlled study of birth centre care versus standard maternity care: effects on women's health. *Birth.*24. 17-26.
Zadoroznyj, M. (2000). Midwife-led maternity services and consumer 'choice' in an Australian metropolitan region. *Midwifery*. 16. 177-185.