School Of Nursing

Australian Midwives' Practice Domain

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ABSTRACT

This exploratory, descriptive research used a case study approach to analyse the role of the midwife in providing maternal and infant care in Australia. Midwives from the states of New South Wales, Victoria and Western Australia comprised the target population. These midwives were considered to be representative of the general midwifery population practising in the diverse settings of Australia.

A triangulation of methods (Denzin, 1970) was used for data collection. This included observational field work, a questionnaire survey of a randomly selected sample of registered midwives (n=1754), and in-depth interviews (n=75), using a grounded theory approach (Glaser and Strauss, 1967; Strauss and Corbin, 1990).

The questionnaire, in-depth interviews and observational field work addressed the practice of midwives:

1. as documented in policies and procedures in practice settings
2. as defined by the Australian College of Midwives Incorporated in *Standards for the Practice of Midwifery* (1989), based on the International Confederation of Midwives' Definition of a Midwife (World Health Organisation, 1976).

Data obtained through the survey questionnaire were analysed using descriptive analysis (Wilson, 1985) to portray a summarization of the entire data set. A thematic content analysis was used for the open-ended questions of the survey (Burnard, 1991). In an attempt to discover the 'how and why' questions associated with the study's survey findings, the constant comparative method of analysis of data from in-depth interviews was deemed appropriate (Glaser, 1978; Field and Morse, 1985; Chenitz and Swanson, 1986). This allowed a more abstract level of conceptualization that led to the development of a paradigm reflective of the midwives' practice domain (Strauss and Corbin, 1990).

Lack of opportunities to practise throughout all stages of pregnancy and childbirth was identified as the major problem limiting the Australian midwives' practice domain. An explanatory process of *Optimising Opportunities for Holistic Midwifery Practice* emerged explaining midwives' actions and interactions throughout

the four stages of optimising: *revealing the image*; *influencing decision making; changing the paradigm;* and *expanding the profession.*

The findings of the study provide an analysis of Australian midwifery practice that considers factors facilitating and/or impeding the professional role and development of Australian midwives, and their ability to provide care that meets consumer needs.

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Preamble

Midwifery practice and the role of the midwife in the care of women throughout pregnancy, childbirth and the puerperium, and the care of the neonate, are receiving increased attention. This could be because women have become more aware and vocal as health care consumers. Fostering such an attitude has been the growing demand from Australian women and their families for perinatal care that is sensitive to psychosocial, physical and informational needs (Commonwealth Department of Community Services and Health, 1989; Health Department of New South Wales, 1989; Health Department of Victoria, 1990; Health Department of Western Australia, 1990).

Furthermore, the Australian Government responded to the findings and recommendations of the ministerial reports from the various states by allocating funds to develop alternative birthing services that would use pluralistic models of care (Commonwealth Department of Community Services and Health, 1989; New South Wales Health Department, 1991; Women's Health Policy Unit, 1991). Accordingly, the Joint Birth Consultative Committee was established in response to the changing scene in the provision of maternity services. Members of this committee, representing the Royal Australian College of Obstetricians and Gynaecologists; the Royal Australian College of General Practitioners; and the Australian College of Midwives Incorporated, expressed concern over the future roles, inter-relationships and responsibilities of professionals providing maternity services (Joint Birth Consultative Committee, 1991; Allen, P. 1991; ACMI, 1992).

Maternity service providers were not alone in their concerns. Within the prevailing downturn of the economy, escalating health care costs were straining financial resources. This stimulated controversy regarding the effectiveness, efficiency and equity of maternity services, and generated questions providing the focus for this research into the practice domain of midwives.

The sphere of practice of the midwife and the scope of midwifery has been defined in the *Standards for the Practice of Midwifery* (Australian College of Midwives Incorporated, 1989). These standards are based on the International

Confederation of Midwives' Definition of a Midwife, from which process and outcome behaviours were defined for each standard of practice. Within this context the study examined the domain of Australian midwifery practice. The International Confederation of Midwives' Definition of a Midwife adopted by The Australian College of Midwives Incorporated and accepted by the World Health Organisation and the International Confederation of Gynaecology and Obstetrics (WHO, 1976), was used as a yard stick to correlate the actuality of practice in Australia.

1.2 Statement of the problem

The role and sphere of practice of the midwife have been defined within the international context. The International Confederation of Midwives' Definition of a Midwife describes a holistic sphere of practice where childbearing women and their families are given supervision, care and advice during pregnancy, labour and the postpartum period. The midwife assumes responsibility for conducting deliveries, and caring for the newborn and the infant (see p.10 for the complete definition). To date, however, the actuality of this practice appears to be shrouded.

Recent consumer reports conducted throughout New South Wales (1989), Victoria (1990) and Western Australia (1991), failed to endorse the concept of holistic care provided by midwives. Rather, consumers voiced concern over the fragmentation of care and lack of continuity of carers.

A study by Barclay (1986) representing midwives' own description of their role and function in the health team found that the midwife's actual role was not manifested or acknowledged. An earlier survey of Australian midwives' perceptions of their practice and training (Barclay, 1985) identified issues adversely affecting the ability of midwives to practise their full role. Both studies by Barclay raised questions about the failure to retain midwives and the consequent wastage to the health care system. Previous research using a task analysis approach to assess the contribution of midwives in New South Wales (Kiiver, 1976) also demonstrated under utilisation of midwives' knowledge and skills within the obstetric services. Similar concerns have been expressed in state reviews on the role of the midwife (Midwives Association of Victoria, 1985; Midwifery Nursing Research Committee - Western Australia, 1986; Midwifery Working Party - South Australia, 1991). These research findings and identified issues and concerns warrant further research into the practice domain of

Australian midwives as a step towards finding relevant answers to the problems.

Although the role of the Australian midwife has featured in historical accounts and sociological theoretical studies (Willis, 1983; Turner, 1987), there has been no research into the actuality of practice correlating to the Standards for the Practice of Midwifery (Australian College of Midwives Incorporated, 1989). Whilst the standards are based on the International Definition of a Midwife (WHO, 1976), the extent to which midwives provide holistic care as promoted in the standards remains unknown. Within this context the purpose of this study emerged.

1.3 Purpose of the study

The purpose of this study was to identify the actual domain of midwifery practice in Australia, according to the Standards for the Practice of Midwifery (ACMI, 1989), and to determine and explain those factors affecting the enactment of the full potential role of the midwife.

1.4 Research questions

The purpose of the study gave rise to the following research questions:

1. what is the actual role of the midwife in Australia in providing obstetric and neonatal care?
2. what are the discrepancies between The Australian College of Midwives Incorporated stated sphere of practice of a midwife and the actual role displayed by empirical data?
3. what are the facilitators and barriers to the enactment of the full potential role of the midwife as defined by The Australian College of Midwives Incorporated?
4. what action / interaction can midwives take to enable them to practise to the full extent of their defined role?

1.5 Justification for the study

A survey of Australian midwives to ascertain their perceptions of their role and function in the health care team was conducted in 1984 (Barclay, 1986). This followed earlier research by Barclay (1985) on midwives' perceptions of their training and practice. The survey examined what midwives regarded as the ideal characteristics for practice and

role fulfilment. Findings from these studies identified discrepancies between the midwives' perceptions of their role and their socially perceived and acknowledged role. The devaluing of the midwife's role by society, from a position of independence and responsibility to one of social and emotional support, resulted in the midwives' traditional authority and expertness being hidden from the general population. This public perception of the diminished sphere of practice was not reflected in the characteristics midwives themselves believed they exercised in their actual role. Further research into the practice domain of Australian midwives is necessary if this anomaly is to be rectified.

A feminist argument was used to explain the issue of overt and covert roles identified by Barclay (1986). The subservient role of nursing with specific reference to the midwifery profession has also been discussed in sociological writings (Willis, 1983; Turner, 1987). Willis, in his discussions on the division of labour in Australian health care states that there exists a 'process of subordination of midwives by the medical profession' (Willis, 1983: 3). From the broader perspective of politico-economic issues he traces the process from the evolution of the medical profession and the English antecedents of the occupation of midwifery, through to the current status of Australian midwifery practice. His account contributes significantly towards an understanding of the present nature of midwifery practice and the role of the Australian midwife, however, empirical research is required to substantiate the actual practice domain.

From an international perspective contemporary literature on midwifery practice places a strong emphasis on a wider sphere of practice. The midwife is viewed as an independent practitioner according to the International Confederation of Midwives, (ICM). This view has been accepted by the World Health Organisation and the International Federation of Gynaecology and Obstetrics (WHO, 1976). While the decade of the 1980's was a time of international concern for the role of the midwife (World Health Organisation, 1985; Donley, 1986; Towler and Bramwell, 1986; Task Force on the Implementation of Midwifery in Ontario, 1987; Kitzinger et al. 1988; Robinson and Thomson, 1989), recent developments in the United Kingdom, New Zealand and Canada demonstrate the increasing visibility and strength of the midwifery profession in these countries (*New Zealand Nurses' Amendment Act,* 1990; Department of Health Expert Maternity Group, 1993; Wilson, 1993; New Zealand College of

Midwives, 1994; Ertley, 1994). The Scandinavian countries and the Netherlands, where midwives are valued and given greater responsibility in pregnancy and childbirth, confirm the benefits of an extended role, as they continue to demonstrate the lowest perinatal mortality rates in the world (Kitzinger, 1988).

Within the worldwide context, Australian midwives too, need to *find their place in the sun.* To do so, this study can be seen as a step in the change process. Reform can begin when the domain of midwifery practice in Australia becomes clearer. Change, however, is not simple. The disparity of practice in Australia calls for multiple strategies. This study, in portraying the domain of midwifery practice, could indicate where and how proposed changes can move forward.

The recommendations of the Joint Committee on Maternity Services (JCMS, formerly JBCC) support the recognition of the midwife's role. Midwives are described as being *ideally placed to function as primary health care professionals. Their sphere of practice has been clearly articulated and agreed at international levels by midwives, their obstetrical colleagues and the World Health Organisation,* (JBCC, 1992: 4). The report goes on to state the weaknesses of the midwifery model of care and improvements are recommended. The Joint Committee on Maternity Services has also considered the responses of the three colleges to the report of the JBCC (JCMS, 1994). The approved recommendations, if implemented, would change childbirth practices and outcomes in a radical way. The important question needs to be asked: are Australian midwives ready to meet this challenge? This study could help midwives to reflect on their practice and recognize where they stand in meeting the future needs of childbirth in Australia.

The consultation document *Options for Effective Care in Childbirth* (NHMRC, 1993) was released for public consultation during 1994. This draft report discussed the implications for maternity services' providers and their consumers in a more detailed way. The final report was endorsed by Council (NHMRC) in November 1995. The emphasis is on childbirth choices for women and their families and the development of an integrated but flexible maternity service using the models of care recommended by the Joint Committee on Maternity Services.

These reports and recommendations endorsed research into midwifery practice. They came at a time when there were rising levels of concern among health service providers at the increasing rates of medical intervention and the corresponding escalation of health care costs (Lumley, 1993; Wagner, 1994). There was also a

mounting political awareness of governments being motivated through economic pressures and the insistent crescendo of the consumer's voice (Health Department of Victoria, 1990; Health Department of Western Australia, 1990, and Gilles, Gee, Rouse and Semmens, 1995).

The Australian College of Midwives Inc. has kept abreast of both national and international factors affecting maternity services and the implications for consumers and providers. The *Action Plan for the Triennium 1994-1997* based on the International Confederation of Midwives' Action Plan developed in Vancouver in 1993, states the following aims:

> to strengthen the profession of midwifery;
>
> to develop the role of the midwife as an autonomous professional practitioner;
>
> to improve the standard of care provided to mothers, women, babies and their families;
>
> to advance the provision of midwifery and women's health services in collaboration with other health professionals and consumers;
>
> and, to advance within the Asia Pacific Region the potential of the midwife, and the value of midwifery in achieving the reduction in the rates of maternal and neonatal mortality and morbidity (ACMI, 1994: 3).

The goals and strategies outlined by the ACMI to achieve these aims have been developed by the executives of the Australian College of Midwives Inc. with the assistance of all state branches. The challenge facing the ACMI is to have this admirable plan for the triennium infiltrate through the college members to practising midwives throughout Australia. The complexity of issues needing to be understood and addressed, to facilitate achieving this, demonstrates the justification of this research into the *Australian Midwives' Practice Domain.*

The empirical data of this study provides an in-depth portrayal of the practice domain of Australian midwives as they perceive it within their practice settings. It also presents a profile of Australian midwives and their perceptions of their contribution towards maternity care for childbearing women and their families. The importance of this study to the care of childbearing women and their families is that it adds to the understanding of social, cultural, economic and professional issues that affect midwives within their numerous and diverse practice settings. Knowledge of what midwives do in each practice setting; the extent to which this meets the ACMI *Standards for the*

Practice of Midwifery (1989); and the midwives' perceptions of the factors that influence their ability to provide care that meets consumer needs is essential if Australian midwives are to exercise their full potential role and sphere of practice.

1.6 Outline of the study chapters

Chapter Two provides a review of literature relevant to the sphere of practice of the Australian midwife. This includes international and national historical and sociological factors that impinge upon current midwifery practice. This forms a backdrop from which this case study is presented.

Chapter Three explains the conceptual underpinnings of the study and the case study methodology chosen to achieve the purpose of the research. The findings from the survey questionnaire are presented in Chapters Four, Five and Six. Chapter Four provides descriptive data on actual midwifery practice; Chapter Five correlates and determines actual practice according to the *Standards for the Practice of Midwifery,* (ACMI, 1989); and Chapter Six identifies factors midwives considered as facilitating or limiting their ability to practise according to the International Confederation of Midwives' definition of the role and sphere of practice of a midwife.

Chapter Seven presents the qualitative data analysis of the interviews with midwives. It is presented in a conceptual paradigm with an accompanying story line that focuses on the main theme, or core category, emerging from the data. The story line, *opportunities to practice throughout all stages of childbirth,* was developed from four major categories affecting midwives' practice opportunities. These categories are described as: practice settings; consumer awareness; medical subsumption and nursing/midwifery integration. The core process affecting the practice domain of Australian midwives was identified as *optimising holistic midwifery practice opportunities.* The four stages of the optimising process, which were identified as: *revealing the image; influencing decision making; changing the paradigm;* and *expanding the profession,* are described and discussed.

The final chapter integrates the quantitative findings (survey questionnaire) with the qualitative findings (interview analysis). The outcomes are discussed in relation to previous research. Implications for midwifery practice and recommendations for further research conclude the study.

1.7 Definitions

Throughout this study the following definitions apply:

International definition of a midwife - 'A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

Sphere of Practice

She/he must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service (World Health Organisation, 1976).

Midwifery	-	means the management and care of
	(a)	women during pregnancy, childbirth and puerperium;
	(b)	the newborn during the puerperium.
Practising midwife	-	a midwife currently registered with one of the nursing registering authorities in Australia.
Antenatal	-	the period of time between conception and the commencement of labour.
Intrapartum	-	the period of time from the commencement of labour to the completion of the third stage of labour.
Postnatal	-	the period of time from completion of the third stage of labour to six weeks following childbirth.
Puerperium	-	the six weeks period following childbirth.

Levels of care	-	as defined by The Australian College of Paediatrics (Appendix 1 Australian College of Midwives Incorporated, 1989).
Perinatal Mortality	-	rates the number of stillbirths (greater than 20 weeks gestation) and neonatal deaths (within 28 days of birth) per 1000 total births in a year (Gee, 1994).
Maternal Mortality	-	rates the number of maternal deaths per 1000 live births in a year (Gee, 1994).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This literature review commences with a summary of the shrouded status of Australian midwifery practice. It highlights the need to openly portray the actual sphere of practice. An extensive review was conducted using computerised literature programmes initially, then broadening out to follow through past research into the historical, sociological and cultural factors affecting the current practice domain.

The search was continuous throughout the study. Current international and national journals and research reports added to the body of literature concerning the world wide role of the midwife in providing maternity care sensitive to the needs of child bearing women and their families. Access to such a broad spectrum of publications was greatly assisted through the Midwifery Contact Centre Library owned by Mrs. Henny Ligtermoet (see acknowledgements). It has enabled the following synthesis of contextual issues to contribute to the understanding of the Australian midwives' practice domain.

2.2 Endorsement of a midwifery model

The Joint Committee on Maternity Services (JCMS) experienced difficulties in defining a midwifery model for Australian midwives. This committee consisted of representatives from the Royal Australian College of General Practitioners, the Australian College of Midwives Incorporated, and the Royal Australian College of Obstetricians and Gynaecologists. The JCMS report highlighted interdependency between all members of the maternity care team, by stating that:

> *The general practitioner or specialist obstetrician has generally provided the antenatal care, the medical practitioner and midwife provided the intrapartum care, and much of the postpartum care has been provided by the midwife. No individual group can do everything completely on their own for all women. Even pregnant women considered to be at 'low risk' are not at 'no risk' and the availability of appropriate care givers for serious, albeit unlikely, problems must be ensured* (JCMS, 1994: 10).

Even though the interdependence of care givers was acknowledged, the eleven recommendations approved by the councils of the three colleges (The Joint Committee on Maternity Services, 1994) refrained from establishing clear guidelines for the role of midwives or medical practitioners. This omission was also apparent in the models of maternity care recommended by the Joint Birth Consultative Committee (JBCC): midwifery care; general practitioner obstetric care; specialist obstetrician care; and shared care (JBCC, 1992: 4-6). The role of midwives, however, as appropriate care givers in normal pregnancy, as well as being an important part of the team caring for women with complicated pregnancies, was endorsed in the recommendations.

The legitimate role of the midwife appeared to come to the fore in 1991. This occurred following the recognition of the value of a midwifery model of care at the Birth 2000 symposium (Rowley, 1991). To support the contribution of midwives, a seven year longitudinal study of hospital care to low risk mothers by a team of midwives, was presented. The results of this study showed favourable outcomes for both mothers and infants. The outcomes were linked to the supportive relationships that developed between the women and midwives during pregnancy. This relationship facilitated the midwife's supportive role during labour, which in turn affected both mother and baby by decreasing the physiological stressors of the birthing process.

Based on the results of the longitudinal study of the midwifery model of care conducted on low risk mothers, it was considered appropriate to include high risk women as well. Subsequently, a randomised controlled trial of continuity of midwifery care for women of all risk followed. The findings were favourable for women within all categories of risk (Rowley, 1995).

The problems associated with limiting the availability of midwifery models of care to women categorised as low risk were identified by Rowley (1991: 5) as:

1. *poor predictive validity of risk assessment criteria;*
2. *reassignment to high risk when problems developed;*
3. *exclusion of women who needed close, personalised midwifery support because they were high risk;*
4. *women self referred because they wanted midwifery care regardless of presumed risk status.*

The benefits of continuity of midwifery care for the women and their babies have been demonstrated through numerous international studies (Flint and Poulengeris, 1987; Frohloch and Edwards, 1989; McIntosh, 1989; Hodnett, 1995, and Waldenstrom, 1996). Midwifery models of care have also been trialed in Australian settings within the larger context of models of maternity services. The four models recommended by the JBCC (1992) all encompassed the midwifery model, with midwives providing care to women and their families within all models. This sphere of practice has been endorsed in the recommendations of the Joint Committee on Maternity Services (JCMS, 1994: 11) recommendation eight:

> *Midwives are appropriate care givers in normal pregnancy, working with appropriate medical liaison. In addition, midwives form an important part of the team caring for women with complicated pregnancies.*

With this endorsement of the role of the midwife within the maternity care team it becomes imperative that Australian midwives establish their professional identity. Their sphere of practice and specific responsibilities within the diverse practice settings and models of maternity service provision, need to be identified and analysed if midwives are to change mainstream midwifery, and expand the benefits of the midwifery model of care to childbearing women and their families, within all Australian maternity service settings, (Waldenstrom, 1996).

2.3 Australian midwifery practice

Australian midwives have been less successful than other health professions in establishing recognised professional status. Explanations of this failure to achieve recognition have been attempted from both macro and micro sociological theoretical perspectives and exponents of midwifery practice ideology (Willis, 1983; Barclay, 1985; Towler and Bramwell, 1986; Turner, 1987; Donnison, 1988; Cutts, 1993; Callaghan, 1996).

Several approaches have been taken towards researching the role of the Australian midwife. A study by Kiiver (1976) analysed the actual tasks performed by those providing obstetric care in a large metropolitan maternity hospital. The level of skill and knowledge required to perform each task was analysed independent to the

qualification or job position of the person allocated to the task. It was found that both medical and midwifery staff spent time on tasks that under utilised their knowledge and skills. In particular, midwives found their time taken up with low level task orientated domestic work, to the detriment of time available for direct care of women and babies.

Following concerns expressed on the delineation of the midwife's role in Australia and its subsumption within the dominant medical model (Burgess, 1978; Shoebridge, 1979), the Midwives' Association requested an enquiry into the training and practice of midwives in Australia. Data produced from the National Survey of Nursing Personnel (1978) had also raised alarm over the wastage of midwives to general nursing. Their findings indicated that 85 per cent of nurses with midwifery qualifications were not employed as midwives (Midwifery Nursing Research Committee, 1986).

In response to these concerns exploratory research was conducted during the early 1980s by Barclay (1984; 1985) into the training and practice of Australian midwives. State and territory requirements for midwifery programs were analysed. It was found that educational programs varied widely (Barclay, 1985). A repeat analysis by Barclay and Haddon in 1992 (Barclay, 1993) showed that variations in requirements and regulations continued. Little change had occurred during the decade.

A study into the perceptions of midwives of their training and practice by Barclay (1985) showed that nearly half of the students on these programs felt inadequately prepared to undertake midwifery practice on graduation. In a recent review Barclay (1995) reiterated her earlier findings as follows:

> *Many students were poorly motivated about undertaking the course, and fewer than 60% were employed as midwives within a year of graduating. The excessive wastage rates in graduates reflected the high proportion of students not intending to practise even while they were actually undertaking programs. The study showed antiquated curriculum models; students who claimed they were treated as menial members of the workforce rather than learners; service delivery taking precedence over teaching of students, and students who felt their clinical experience was inadequate for practice* (Barclay, 1995: 101).

An Australian wide survey by Barclay (1986) was designed to determine midwives' own perceptions of their role and function in the health team. Rather than using a task analysis approach to the study, 405 midwives were surveyed to obtain their

individual subjective perceptions of the qualities and characteristics they believed were essential for the practice of midwifery. Midwives were asked to nominate five from fifteen predetermined characteristics they perceived to most accurately define their role. The findings demonstrated that midwives saw themselves working in a *controlling and active role*, rather than *a passive and counselling role.* There was consistency across the states, presenting an Australian profile of midwives perceiving themselves to be highly analytical, accepting considerable responsibility for the conduct of birth. Barclay postulated that the midwives' actual (though not acknowledged) role remained much the same as it had been historically. She argued that despite economic, political and social systems that diminished the midwife's public sphere of responsibility, the midwife still required and used the characteristics of an independent practitioner.

The issue of overt and covert roles identified by Barclay (1986) is reflected in the reports of various state working parties (Midwifery Nursing Research Committee, 1986; Midwifery Working Party Report, 1990; Health Department Victoria, 1990). The internationally accepted definition of a midwife has been acknowledged in these reports as having wide acceptance in Australia. Also acknowledged is the fact that few midwives are able to practise in full accord with it. The reports state that this is regrettable and results in the under utilisation of midwives' skills. It is also seen as a likely factor in the low workforce participation of midwives holding certification to practise midwifery (24.5%), (Health Department Victoria, 1990). Issues identified as needing to be addressed included: the scope and sphere of midwifery practice; midwifery education; midwifery registration; accreditation of independently practising midwives, and hospital visiting rights for midwives.

Barclay (1995) addressed the unresolved issue of the educational preparation of midwives in Australia. She linked her previous research to the changing context within which developments and debates on the sphere of practice and the educational preparation of the Australian midwife were occurring. Barclay provided insight to the past and present trends, and future direction for the education of midwives.

Recognition of Barclay's (1995) valuable contribution to midwifery education which acknowledges the uniqueness of the Australian context, highlights the need to portray the domain of midwifery practice in this country. To do so, a return to the past from which the current practice domain emerged is a pre-requisite.

2.4 An historical perspective

The influence of temporality in the form of past, present and future is emphasised by Strauss and Corbin (1990). Every interaction, organisation, nation and special interest group is seen to have a history. This history has consequences for present action/interaction; with past and present becoming part of the future.

The relevance of the British antecedents to Australian midwives has been well recorded by Willis (1983). His use of a conflict approach to the historical development of the medical and nursing professions' dominance of the once autonomous occupation of midwifery, provides the backdrop which enhances an understanding of the present relationships between these professions.

A conflict approach has characterised many of the historical accounts of midwives and midwifery practice. This has been demonstrated by international feminist and social science writers with accounts, dating back as far as the early Old Testament books of the Bible, depicting conflict situations (Oakley, 1980; Rothman, 1982; Kitzinger, 1988). The middle ages saw the struggle between women healers and the medieval church culminating in midwives inclusion as the victims of vicious witch hunts (Forbes, 1966; Ehrenreich and English, 1973; Chamberlain, 1981; Donnison, 1988). The early seventeenth century ushered in the man - midwife contributing to the establishment in the mid-eighteenth century of the lying- in hospitals (Towler and Bramwell, 1986). These hospitals, Versluysen (1981) argued, set an important precedent in the history of childbirth since they provided a model of childbirth conveniently managed by man-midwives within an institutional setting. This trend towards male control over childbirth met with vigorous opposition from female midwives as there was little place for them to continue their autonomous practice within these lying- in hospitals. Employment was commensurate to subordination by the male-midwives (Versluysen, 1981; Willis, 1983; Tew, 1995). Australia inherited this past, just as this country inherited the people of Britain imbibed with such a past.

2.4.1 The emergence of medical dominance

An historical study by Chamberlain (1981) traced the growth of the medical profession in relation to the rise of the middle classes. The institutionalisation of medical knowledge promoted the concept of expertise as an institutional status rather than a capacity of practice. This expertise was jealously guarded and protected from those

considered unable to comprehend its complexities. The wise and cunning women, once experts, were relegated to caring for women unable to afford the services of the rising medical profession. The increase in the number of medical practitioners was closely linked to the expansion of the middle classes with their deference to the experts. Thus diagnostic and prescriptive practices became the prerogative of the physician rather than the women healers and midwives. The incentive for middle class women to practise healing decreased as the ideology of the day promoted idleness as a status symbol for middle class women, which reduced the status of the woman healer and midwife. The expansion of the medical practitioner into the market of middle class midwifery continued. Their popularity grew as their administrations to the wealthier were not hampered by many of the communicable diseases and poverty related illnesses adversely affecting the outcomes for the urban poor (Chamberlain, 1981; Tew, 1995).

Furthermore, where the medical practitioner had been called in by midwives for abnormal cases, they now moved into direct competition with midwives for normal births. By the middle of the eighteenth century there were about several hundred men-midwives practising in London and its environs (Donnison, 1988). The trend towards male involvement was greatly accelerated by the development of the midwifery forceps, which were restricted for use by male practitioners. This enabled the male practitioners to deliver live infants where previously either mother or child may have been lost. The distinction of the great men-midwives, such as Richard Manningham, Fielding Ould, William Smellie and William Hunter, also reflected credit on every male practitioner, deservedly or not (Donnison, 1988).

Midwives were concerned about their declining opportunities to practise. This concern, according to Towler and Bramwell (1986) prompted Mrs Sarah Stone in 1737 to publish her *Complete Practice of Midwifery* in the hope that it would enable women *even of the lowest capacity* to deliver their patients successfully. She believed that unless women showed themselves capable of delivering difficult cases, the public would bypass them in favour of a man-midwife. Midwives access to instruction in dealing with difficult cases, however, remained guarded by male practitioners. According to Donnison (1988) Thomas Dawkes in 1736 wrote *The Midwife Rightly Instructed.* This was a question and answer book which had the surgeon refusing to tell the midwife how to deal with a haemorrhage. Rather, the author warned the midwife *not to aspire beyond the capacities of a woman.*

The expansion of male midwifery practice was also not welcomed by the ranks of medicine who believed that the surgeon alone should be involved in difficult cases. This initiative was promoted by John Douglas, a London surgeon, who demanded the establishment of lying - in hospitals in all the principal cities of England. The same opportunity for the training of English midwives as those for the French midwives at the Hotel Dieu was also advocated. Douglas acknowledged the career of Madame du Tertre, a past head midwife of the Hotel-Dieu, who demonstrated that high standards could be achieved through the training of midwives (Donnison, 1988). These events were significant in allowing the medical profession to attain a prominent position in controlling the training and practice domain of midwives, both in the community and in the hospitals.

By the 1850s, despite repeated proposals for the regulation and training of midwives, this had not been achieved. In fact, such was the stigma attached to the occupation that educated entrants were a rarity. In comparison, the social recognition afforded the emergent general practitioner within the specialty of obstetrics continued to rise. With the position of the midwife at an all time low, her demise was imminent. Donnison (1988) states that without external help the downward trend would have continued, with midwives becoming *monthly nurses* trained to satisfy the needs of the well-to-do in society, and to perform the routine functions surrounding childbirth that were seen as time wasting to the attending medical practitioners.

2.4.2 Colonial influences

The social reforms that occurred in England as a consequence of the appalling conditions in the crowded work houses and infirmaries coincided with, and contributed to, the assisted emigration of the poor to the open spaces of England's new colonies. Burchill (1992) describes the far reaching effects of these inter-woven events on the early development of nursing in Australia. In particular, the international influence of Florence Nightingale and the impact of the Nightingale Nurses on the way nursing and midwifery were to develop within the Australian society, is presented from an historical, story telling perspective. While not a critical approach, Burchill's work is well researched and supported by primary documents and personal communications from this pioneering era. As a registered nurse, midwife, and infant and maternal health nurse, her account of Australian Nurses since Nightingale 1860-1990, provides demonstrated

evidence of the merging of the skills and knowledge bases of these separately obtained qualifications when practised in the diverse settings throughout Australia. Her account of the work performed by bush nurses, border nurses, district nurses and infant welfare nurses, indicates the historically unquestioned need to be able to provide care in all situations. Midwifery and infant welfare qualifications were seen as necessary adjuncts to general nursing. Once gained all were used to provide the multi-faceted needs of the pioneering communities, urban, rural and remote, (Hall, 1987; Durdin,1991).

There is little information available about the early immigration of midwives to Australia. Durdin (1991), however, refers to the lowly status of midwives as portrayed in an analysis of the assisted immigrants who arrived in the colony between 1836 and 1840. Midwives were among the miscellaneous category of 'domestic servants', along with nurse-maids, laundresses, housemaids and charwomen. Durdin describes the role of the 'granny midwife' who went from home to home assisting at the birth and staying on to care for the mother for four weeks after the birth. A few midwives, usually widows needing to support their own families at home, opened one or two rooms in their homes to provide a rudimentary cottage hospital. Accounts of women assisting one another in childbirth feature in early pioneer history (Pownall, 1964; Teale, 1978), however, little has been recorded of the actual role of the midwife.

Recognizing the paucity of early midwifery history, a chronological account of midwifery practice in the different Australian states was prepared by the Western Australian Branch of the National Midwives Association of Australia for the 20th Congress of the International Confederation of Midwives held in Sydney in 1984 (McDonald and Davis, 1984). Members of the College from each state compiled a brief, but factually concise description of midwifery from the time of the early convict era (1788-1850) and the early settlers, to the time of writing. Hayes, Bayliss and co-workers (1984) recorded the New South Wales experience within four time dimensions: the convict era (1788-1850); colony to nation (1850-1900); early nationhood (1900-1950); and the era of increasing technology (1950-1984). A similar pattern emerged throughout each of the states' recorded histories. Early settlers were reliant upon each other for assistance, with some women becoming recognised for their knowledge and experience in assisting at birth. The infirmaries for convict women were the beginnings of institutionalised confinements, with female convicts who became pregnant being sent to the female factories for *lying - in.* These patterns of midwifery were reminiscent of the early British era.

2.4.3 The trend to hospitalisation

Training for midwives had commenced in maternity hospitals within each of the cities by the early 1900s. These teaching hospitals catered for the poor and destitute. In New South Wales and Victoria training schools were established before the commencement of the 20th century. The turn of the century saw increasing concern with the high levels of infant mortality and the falling birth rates. A Royal Commission Report in 1904 encouraged hospitalisation for confinement. It was not long before teaching hospitals were overflowing, and new hospitals were built. Private cottage hospitals were also opened by midwives who had graduated through the teaching hospitals.

Willis (1983) refers to the period from 1910 through to the late 1930s as *the takeover period.* He argues that with the growing concern over high infant mortality rates and falling birth rates midwives became the scapegoat to blame. This, Willis states, was the case in the New South Wales 1904 Royal Commission, despite the fact that the more affluent middle class women attended by doctors were at greater risk of infection than the poorer women attended by the midwife. With continued claims that puerperal fever was the result of the practice of midwives, there was a call for the exclusion of midwives from attending childbirth. The state was also evoked to control the practice of midwives. At the same time state patronage for the medical profession consolidated their dominance over other health occupations. *The subordination of midwifery was formally achieved through its limitation in various midwifery registration acts from 1915 to 1920, and its final and formal incorporation into nursing in 1928* (Willis, 1983: 111).

2.4.4 Social and environmental influences

The honour for the decline in death rates after 1870, rightly or wrongly, was given by the grateful public to the medical profession. The epidemiological explanation for the decline in mortality disclosed in the 1950s and 1960s (McKeown, 1976) was greeted with general surprise and scepticism, revealing how deeply ingrained was the popular misconception of the powers of doctors. These attitudes towards health and illness are seen by Tew (1995) as contributing to society's belief that *although reproduction is not a disease, its problems are better solved by medical intervention than by environmental improvement and healthy life styles. And,* adds Tew, *since the prosperity of doctors concerned with maternity care is vitally dependent on this belief, it is understandable that they should make great efforts to propagate it* (Tew, 1995: 5).

Biographies, autobiographies, and historical accounts (Allen, 1955; Forster, 1967; Hagger, 1979; Priestley, 1986; Hall, 1987; Durdin, 1991; Burchill, 1992;) record the hardships faced in the struggles towards nationhood. The impact of poverty and class, rural, and urban lifestyles, and isolation in remote areas characterise the accounts of the experiences of childbearing women and their families as Australia struggled towards nationhood. Midwives, nurses and medical practitioners faced challenges and hardships in the provision of maternal and infant care within the demanding social, economic and geographic environments of the early pioneer years. Such was the environment in which the domain of midwifery practice grew and developed.

A new age was ushered into the history of maternity care by the 1950s. It was described by Hayes and Bayliss (1984) *as the era of increasing technology.* The international complexity of world wide social, political, economic and cultural influences, also touched the lives of all Australians. This was particularly so following the second world war when Australia opened its doors to extensive immigration policies, initially for skilled European labour, but later extending to Asian countries (Cathcart, 1995). Recipients and providers of maternity care together impacted on the practice of midwifery.

2.5 Socio-economic and cultural influences

The difficulties experienced by today's non English speaking background childbearing women and their families are directly proportional to the length of time spent assimilating into the Australian culture (Health Department of Victoria, 1990). The study group noted *a lack of understanding of, or respect for, women's cultural or religious practices and beliefs.* This has been a recurring feature in the consumer studies conducted throughout Australia by various health departments and government bodies.

Research identifying differing outcomes for childbearing women within different social and cultural groups was difficult to access. The midwives' notification of birth system has been in place for some years in all Australian states. Statistics gathered through this system indicated clinical procedures and the immediate birthing outcomes for mothers and babies. Annual reports were available but the levels of analysis differed between states. There were findings that were consistent across all states. Prominent amongst these was the high rate of medical intervention in private health care organisations and large public teaching hospitals, as compared to non teaching

public hospitals. Health areas identifiable as providing services to childbearing women in suburbs with a high non English speaking population indicated a lower rate of medical intervention (New South Wales Health, 1993; Perinatal Data Collection Unit, HDV, 1993; HDWA, Gee, 1994).

Gee (1991) used data collected from the Registrar General's Office, the Hospital Morbidity System, the Community and Child Health Services and the Australian Bureau of Statistics (Western Australian Branch) to prepare a report of perinatal and infant mortality in Western Australia for 1989. Comparisons were made of stillbirth rates between Caucasian and Aboriginal women, and babies of women of other races. The stillbirth proportions were 9.5/1000; 19.4/1000; and 10.8/1000 respectively. Neonatal mortality comparisons were: Caucasian 4.4/1000; Aboriginal 7.7/1000; and other races 6.6/1000. The perinatal mortality proportions were: Caucasian 10.2/1000; Aboriginal 19.4/1000; and other races 10.8/1000. In addition to the proportions between races, Gee provided comparisons between perinatal mortality among babies of single women (15.5/1000) and babies of separated, divorced or widowed women (17.2/10000 , with babies of women reported to be socially supported by a male partner (9.5/1000) (Gee, 1991: 19).

Of prime importance is the perinatal mortality rate for Aboriginal babies. Gee, (1991) summarises the comparisons between Aboriginal and non Aboriginal infant mortality as being almost three times the overall proportion (22.4/1000 compared with 7.8/1000). These figures are despite substantial decreases in Aboriginal infant mortality over nine years from 31.3/1000 in 1980 to 22.4/1000 in 1989. In Western Australia in 1993 the perinatal mortality rate for Aboriginal babies was almost twice as high as that of non-Aboriginal (13.2/1000 compared with 7.0/1000) (Gee, 1994). The need for improved services to Aboriginal women and their families has been emphasised in the reviews of maternity services (HDNSW, 1989; HDV, 1990; HDWA, 1991). Extensive consumer reviews throughout these states confirmed that the social situation in which many Aboriginal women found themselves had a profound effect on their experiences of childbirth, and child caring. Lower than average incomes, high unemployment rates, poor housing, and a culturally insensitive health care system, were acknowledged contributors to the discrepancies between Aboriginal and non Aboriginal perinatal mortality rates in all states.

Waldenstrom (1995: 493-502) speaking at the Australian College of Midwives Ninth Biennial Conference in Sydney, highlighted the impact of differing midwifery cultures on the varying cultural needs of childbearing women. The attitudes of maternity care providers towards long standing models of midwifery care provision were questioned in light of more women and family focused, culturally sensitive and appropriate options. According to Waldenstrom, a change in attitude, from *staff orientation* to *women orientation* is crucial, not only to provide culturally sensitive care, but also to meet the common interests of consumers and providers of maternity services - safe, sensitive midwifery care that meets individual needs, whether these are psychological, social, religious or cultural.

2.6 International influences

In the childbirth arena Australia adopted the medical model which dominated pregnancy and childbirth in the United States. Increasing medical intervention in childbirth posed a threat to the practice of midwives. They became an assistant to the medical practitioner as the rate of active management of labour and birth by forceps delivery or Cesarean section increased (Forster, 1967; McDonald and Davis, 1984; Barclay, 1985; Cutts, 1993). In discussing the role of the Australian midwife from an international perspective Barclay states:

> *Social, political and economic systems have impinged further and further on to midwifery in Australia, so there is very little remaining independent territory for the midwife, except in a subsidiary role. Notable exceptions are the relatively few midwives who work in the home birth movement and those in isolated outback regions* (Barclay, 1988: 90).

Midwives of Australia are not isolated from their counterparts abroad. International challenges facing midwives are linked through historical ties. Just as the inheritance of colonial societal influences continues to dominate Australian midwifery, so too has the role of the midwife been affected in countries with a similar inheritance. Progress and change require constant reviewing and reflection of international practice in order to meet today's global needs for childbearing women and their families.

A study on the role of the midwife in the United Kingdom undertaken in 1979 (Robinson, 1989) analysed the role and the responsibilities of the midwife.

The study was based on the premise that:

> *midwives trained in the United Kingdom are qualified to provide women with care throughout pregnancy, labour and the puerperium on their own responsibility and to recognize those deviations from the normal that require referral to medical staff for advice and treatment, that is, in accordance with accepted international definition of the role of a midwife (World Health Organisation, 1966: International Congress of Midwives/International Federation of Gynaecology and Obstetrics, 1973) (Robinson, 1989: 10).*

This study was conducted using semi-structured interviews with midwives working in a variety of practice settings. A range of other maternity care personnel were included to help identify the issues current in the late 1970s. This national survey of midwives, obstetricians and general practitioners conducted in the United Kingdom in 1979 found that although midwives provided most of the care for childbearing women, many were not able to exercise their clinical judgment. Data from this study has provided a benchmark for the role of the midwife in the late 1970s, against which subsequent studies on more specific aspects of midwifery practice have been compared.

The international implications of the findings of this United Kingdom study were widespread. It had demonstrated that although midwives carried out a major part of the care provided to childbearing women they were unable to exercise fully the degree of clinical responsibility for which they were trained and qualified. There was a wide variation in the degree of responsibility midwives were able to exercise within different practice settings. Decision making in normal pregnancy, labour and postnatal care had been assumed by the medical profession, thus limiting opportunities for midwives to retain their skills. Unit policies determined by medical staff alone or medical staff in consultation with senior midwives, required midwives to follow a predetermined course of action whether they considered it appropriate or not. The survey demonstrated that midwives working in general practitioner units were much less likely to have their responsibilities for decision making eroded than those working in specialist consultancy units (Robinson, 1989). The implications for the quality of care available to women, through failure to utilise the clinical skills and judgement of the midwife, was that care was fragmented into tasks performed by different personnel.

These findings have been substantiated by other studies where practising midwives in the United Kingdom, and representatives of statutory and professional bodies and parliamentary committees, have expressed their concerns of the under use of midwives. This resulted in consumer dissatisfaction and a lack of continuity of both care and carer (Maclean, 1980; Social Services Committee, 1980; Royal College of Obstetricians and Gynaecologists, 1982; Maternity Services Advisory Committee, 1982; Morin, 1982; Towler, 1982; Roch, 1983; Central Midwives Board for Scotland et al., 1983; Garcia et al., 1985; Royal College of Midwives, 1987; Kitzinger, 1988; House of Commons Health Committee, 1992; Department of Health, 1993).

Another factor influencing midwifery practice was that of hospital policy. This included both written and informal policy. Written policies tended to be varied, with some being diametrically opposed between one unit and another. Others were in the form of detailed information that left no opportunity for the midwife to use her own clinical judgement (Garcia and Garforth, 1991). Unwritten informal policies influencing midwives' practice were seen as the *politics behind policy documents*. Similarly, attitudes within practice settings reflected the basic philosophies of different obstetric units. In a study into the effects of staffing structures in six maternity hospitals in the south east of England the impact of the unit ethos, or the unwritten dominant attitudes and assumptions, was considered just as important as the formal policies and structures, (Green, Kitzinger and Coupland, 1994). Examples of differing philosophies (or unit ethos) were described as: *active birth and midwives' autonomy; women's right to choose; consultants rule;* and *legal liability - Who is responsible?*

Further evidence on the effect of policies on practice is provided by Enkin, Keirse and Chalmers (1990). They combined the findings of studies on hospital policies and admission practices in their collection of research findings, and concluded that:

> *The marked variations that exist in the types of care women receive depend more on which maternity unit a woman happens to attend, and which professional she consults, than on her individual needs or preferences. These differences in practice are often so dramatic that they cannot possibly be explained by differences in medical indication or by the preferences of the women attending the different hospitals* (1990: 179).

Accordingly the researchers recommended the following:

> *Controlled trials are required, to evaluate not only the effects of routine hospital policies and practices, but also the methods of implementing changes when these practices are ineffective, inefficient, or counterproductive* (1990: 183).

The findings of the English study on the role of the midwife (Robinson, 1989) demonstrated that midwives were often unaware of their dependence on policies and procedures in their clinical practice. Midwives tended to overestimate the extent to which they made decisions based on their own clinical judgment, and underestimate the extent to which they practised according to prevailing unit policies. Other studies conducted in England, Wales and Scotland during the 1980's, on the role of the midwife and the effect of policies and procedures within different organisational settings and medical structures, identified the anomaly that although midwives stated their practice was restricted, there was not a correspondingly high level of expression of dissatisfaction (Robinson, 1989; Garcia and Garforth, 1991; Green, Kitzinger, and Coupland, 1994).

The findings of research into midwifery practice in the United Kingdom set in train an effort to re-establish the role of the midwife. A proliferation of recommendations for the re-establishment of the midwife as the primary care provider for women throughout normal childbirth, in the United Kingdom, was accompanied by research into midwifery practice and education. The role of the midwife as caregiver for women with normal pregnancies was endorsed in a summary of conclusions drawn from studies that met the research requirements stipulated according to *The Cochrane pregnancy and childbirth database* (continually updated). Similarly in a collection of research studies by multiple researchers, in *Effective care in pregnancy and childbirth* (Chalmers, Enkin and Keirse, 1989), the benefits of care provided by midwives with medical back-up were compared with medical or shared care. The studies demonstrated that:

> *midwifery care was associated with a reduction in a range of adverse psychosocial outcomes in pregnancy, and with reductions in the use of acceleration of labour, regional analgesia/anaesthesia, operative vaginal delivery, and episiotomy. No differences have been demonstrated in the rates of labour induction, pharmacological analgesia, or*

> *Caesarean section. Midwifery care also resulted in fewer babies weighing less than 2500 grams, needing resuscitation, or needing admission to special care units* (Enkin, et al. 1995: 1).

Another finding of international importance established through this research was that:

> *evidence from a controlled trial showed that women who had continuity of caregivers were less likely to use pharmacological analgesia or anaesthesia during labour and birth, to have labour augmented with oxytocin, to have a labour length of more than six hours, or to have a baby with a 5 minute apgar score below 8. They were also more likely to feel well prepared for labour, perceive the labour staff as caring, feel in control during labour, and feel well prepared for child care* (Enkin, et al. 1995: 16).

The efforts to re-establish the role of the midwife brought into focus the benefits this could provide, such as continuity of care. This in turn led to the other side of the coin which was consumer satisfaction.

2.6.1 Consumers' views

Consumer studies and reports at international and national levels have established women's preference for continuity of care throughput pregnancy and childbirth (Flint and Poulengeris, 1987; Davies and Evans, 1991; Thomson, 1991; NSWDH, 1989; HDV, 1990; Bartlett and Pennebaker, 1991; HDWA, 1991; Women's Health Policy Unit, 1991; Department of Health, 1993; Campbell and Macfarlane, 1994; Rowley, 1995; Select Committee on Intervention in Childbirth, 1995; NHMRC, 1996). These evaluative studies and reports recognised the role of the midwife in providing consumer focused care within all models of service delivery.

The findings of international research into maternity practices and models of service delivery are reflected throughout the Australian consumer studies and reports conducted through state Health Departments (Health Department of South Australia, 1987; Health Department of New South Wales, 1989; Health Department of Victoria, 1990; Health Department of Western Australia, 1990 and 1995). These task force reports focused on all aspects of maternity care provision, but they also provided an overview of consumers' views on the care provided by midwives, and the impact of the midwives' actions and interactions on childbearing women and their families within the various models of maternity services.

The Survey for Mothers conducted in Western Australia during May, 1989 (Bartlett and Pennebaker, 1990), provided a wealth of information that was included in the Ministerial Review (HDWA, 1990). In addition, qualitative data obtained through the written comments of these mothers in response to open ended questions and invitations for free comment, were analysed (Cullen, 1991). The major theme identified was: *the behaviours of health care workers were the most frequently stated factors affecting the satisfaction of the consumers of obstetric care services.* These behaviours included: *the giving or withholding of relevant information; the interaction and communication between health providers and consumers; and the availability of the expected service by the health professional* (1991: 1).

A comparison of the findings of the surveys of mothers conducted in Western Australia in 1989 and 1995 indicated that little had changed in the provision of maternity services during the last six years. The impact of the interactions of maternity care providers with consumers during pregnancy and birth were clearly reported in both surveys. Specific issues that were emphasised by mothers in both surveys included: more emotional support; greater continuity of care; more respect by maternity staff; and more consistent advice regarding breast feeding (Gilles, Gee, Rouse and Semmens, 1995).

Similarly, the Victorian ministerial review of obstetric services (1990) also identified dissatisfaction amongst mothers with health care providers in the areas of information giving, interpersonal communication between providers and consumers, and the availability of choices amongst models of maternity service delivery.

A Western Australian study (Percival, 1991) investigated the relationship between midwifery care given during the first two months after the birth of the first infant, and the maternal emotional well-being, confidence in, and satisfaction with motherhood and infant care. The findings of this study demonstrated the impact negative input and unmet expectations of midwives had on mothers' emotional well-being and satisfaction with motherhood. Again, the need for information, support, effective interpersonal communication, and the availability of the midwives' care were the dominant themes identified

Consumer studies have been conducted over the past 20 years in Australia, UK and Europe, Canada and USA. Commonly occurring themes were revealed by authors such as Field (1985); Taylor (1986); Drew, Salman and Webb (1989); Jacoby and

Cartwright (1990), and through the major reviews, *Having a Baby in Europe* (WHO, 1985), and *Changing Childbirth* (UK Ministerial Taskforce, 1993). The identified themes showed that in all stages of maternity care there was the desire to have more choice in all aspects of care and treatment; continuity of care and carer; and improved communication between carers and consumers.

Consumers' views have also included their perceptions of midwives. A study by Field, Campbell and Buchan (1994) showed that the midwife's attitude, knowledge, concern and respect for parents, and the ability to listen to patients' opinions, were the major sources of satisfaction. In another study by Field (1987) there were, however, examples of negative behaviours, including unresponsiveness to mothers' needs, conflicting advice, and making mothers feel guilty about their decisions.

In international attempts to re-establish the role of the midwife, consumer views have been taken into account. Also important, however, is the need to examine where the midwife stands in terms of the medical profession; an examination that begins with the medical and social models of practice.

2.6.2 The medical versus the social model

The focus on the abnormal and the perceived risks attached to childbearing has received attention from social scientists from differing sociological perspectives (Arms, 1975; Corea, 1977; Rich, 1977; Taylor, 1979; Oakley, 1980; O'Brien, 1981; Rothman, 1982; Willis, 1983; Turner, 1987; Sullivan and Weitz, 1988; Donnison, 1988; Kitzinger, 1989; Garcia, Kilpatrick and Richards, 1990).

The medical model can be seen as utilising medical procedures to make birth as pain free and safe as possible for both the mother and the baby, while the natural model argues that birth is a normal process, not an illness, and unnecessary medical intervention can bring about iatrogenic complications (Bennett, Etherington and Hewson, 1993). These authors suggest that a majority of women place themselves in the middle of these polarised models, namely; they would like to give birth naturally but they are unsure of their ability to do so. Rather than a dichotomy between the medical and the natural, the authors speak of a *risk orientated/health orientated* dimension and a *being delivered/giving birth* dimension. Combining these two dimensions gives four distinct models that reflect the underlying assumptions of models of Australian maternity services. These models have been identified as: *risk orientated/being*

delivered; health oriented/being delivered; risk orientated/giving birth; and *health orientated/giving birth.* The dominant cultural belief in Australian society, on the risk orientated/health orientated dimension, is skewed towards the risk end (Bennett, Etherington and Hewson, 1993). Hospitals are seen as the safest places for birth, and the specialist obstetricians as the safest professionals to provide obstetric care. A prophylactic approach is taken to prevent, diagnose, and treat complications identified as risk factors during pregnancy and childbirth. Accordingly, the dominant medical model has successfully propagated the concept that birth is only normal (and safe) in hindsight. Conversely, the health orientated dimension sees every pregnancy as normal unless there are indications that something is wrong (Savage, 1986).

From the prevailing models of practice, terminology has emerged which has been criticised by feminist writers for the disempowering connotations for childbearing women (Rich, 1976; Corea, 1977; Oakley, 1979; Leap, 1992). Being delivered, these authors state; suggests a woman placing herself passively in the hands of the professionals who are the experts in conducting the delivery. Giving birth, in contrast; is the epitome of the power and wonder of the woman's body as she is actively involved in the birthing of the baby she has nurtured throughout the months of pregnancy. The concept of *active management of labour* uses medical interventions to hasten the delivery, depriving the woman of the opportunity to be attuned to the natural physiological birthing processes. This is in stark contrast to the concept, described as *active birth,* where women maintain control of their bodies and are fully involved in giving birth (Balaskas, 1984; Odent, 1984; Flint, 1986).

The effect of the risk orientation dimension within these models of care on midwives' holistic practice opportunities has been discussed in birth centre reviews and studies. The generally accepted philosophy within these settings is that pregnant women with a low risk of complications can be selected by a doctor for total midwifery care by a team of midwives. The midwives aim to provide a non interventionist approach for uncomplicated pregnancies, with ready access to obstetrical and paediatric assistance if complications are detected. Women, and midwives have the reassurance of rapid medical intervention should any deviation from the normal occur. There are recognised risk indicators guiding and controlling practices within these models of care.

Callaghan (1996) using a grounded theory approach, identified two models of midwifery care. These were termed as *Hands On* and *Hands Off.* The medical

interventionist model was the *Hands On* and the midwifery non-interventionist model the *Hands Off.* The study compared the practices of midwives within three major Brisbane hospitals with those of homebirth midwives in two local homebirth groups. The medical model was the predominant model practised by hospital based midwives. The midwifery model was provided by homebirth midwives and a small proportion of hospital based midwives. Thus, the overall modes of practice were along a continuum rather than a stark dichotomy of the two. The findings of this study demonstrated that some midwives can, and do, practice 'midwifery'.

Another promising feature in the practice of midwifery is that risk orientated/giving birth dimensions of midwifery care have been well recommended in recent international birthing services reviews (World Health Organisation, 1985; *Changing Childbirth,* 1993; National Health and Medical Research Council, 1995). These recommendations overlap with the final dimensions of health orientation/giving birth and involve the role of the midwife within a midwifery model of care, prevalent in birth centres and domiciliary settings.

With the focus on risk factors as selection criteria for women to give birth at a birth centre, there is a history of a high transference rate to traditional antenatal, intrapartum and postnatal care settings (Child, 1986; Morris, et al. 1986; Permezel, Pepperell and Kloss, 1987). More recent studies have demonstrated that less stringent exclusion criteria have reduced the high transfer rates whilst maintaining a consistently high level of safety for women and their babies (Biro and Lumley, 1991; Waldenstrom and Nilsson, 1993; Rowley, 1995).

The safety of home birth, and the impact of this model of care on the role of the domiciliary midwife, has been demonstrated in historical accounts and studies. Sporadic home birth community practices have demonstrated safety indicators that compare well with international maternal and infant mortality rates (Gaskin, 1975; Wertz and Wertz, 1977; Breckinridge, 1981; Marland, van Lieburg and Kloosterman, 1987; Campbell and Macfarlane, 1987; National Health and Medical Research Council, 1987; Sullivan and Weitz, 1988; Bastian and Lancaster, 1992; Marland, 1993). This supports the notion of autonomy of practice in the domain of midwives.

A study of planned home births in Western Australia from 1981-1987 found that there was less maternal and neonatal morbidity associated with home births than hospital births (Woodcock, et al. 1994). A report on planned homebirths in Australia between

1988-1990 indicated an overall perinatal mortality rate of 6.4 per 1000 total births. During 1985-87 the perinatal mortality figures for reported homebirths was 5.9 per 1000 births. This was lower than the overall national perinatal mortality rate. Rates of intervention were consistently low. Approximately 10% of women planning homebirth at the outset of labour were transferred to hospital. Of the 3,021 home births reported to Homebirth Australia, a total of 2,726 (90.2%) were born at home (Bastian and Lancaster, 1992). While there is much controversy over the interpretation of statistical data, the National Health and Medical Research Council have acknowledged that there is no evidence supporting concerns that the option for responsible homebirth is not a safe one (NHMRC, 1987; NHMRC, 1995).

The impressive history of home birth in the Netherlands, and its continuing momentum, has established this country as a Mecca for Midwives (Rothman, 1992). The natural paradigm (health orientated/giving birth dimensions) has remained dominant over the competing medical paradigm (risk orientated/being delivered dimensions). The perinatal outcomes maintained by the Dutch Model have ensured the Netherlands' perinatal mortality rates have remained within the top eight nations of the world from 1948 -1993 (figures compiled by H. Ligtermoet from international annual statistics published in the American Journal of Paediatrics).

2.6.3 A changing paradigm

New Zealand has responded to the challenge to the role of the midwife portrayed in the critical, historical account by the internationally recognised midwife campaigner, Joan Donley (1986). The decline of the role of the midwife throughout this century, and the subsequent increase in medical intervention, is demonstrated through detailed Health Department statistical mortality and demographic data. Throughout her analysis of New Zealand maternity services Donley refers to the World Health Organisation definition of a midwife. Under this definition, Donley states:

> *the midwife is essentially an autonomous practitioner whose primary responsibility and loyalty is to the labouring woman and her baby. She will utilise all her skill and experience to assist the woman to achieve a normal birth, if that is possible. ... The W.H.O. definition of a midwife has been adopted by the Midwives Section of the New Zealand Nurses' Association. Yet ever since the Nurses Act of 1971 midwives in New*

> *Zealand have not been autonomous. They are required to work under medical supervision, they are accountable to doctors. Their status is effectively that of a maternity nurse and they are firmly locked into the nursing profession* (Donley, 1986: 16).

Throughout her analysis of the role of the midwife in New Zealand Donley emphasises the interdependency between women as consumers of maternity services and midwives as the guardians of normal pregnancy and birth. The political influence of this work by Donley resulted in the women's movement and consumer groups combining with midwives to bring about change. Consultation between consumer groups, hospital and domiciliary midwives and doctors, resulted in the document, Care in Pregnancy and Childbirth (New Zealand Department of Health, 1990), acknowledging that childbirth is part of the normal life experience of women. This was a first attempt at establishing national guidelines *for the development of policy for safe options for low risk pregnancy* (NZ Department of Health, 1990).

Donley (1995) details the impact of the legislation passed in October 1990 aimed at *providing women with a wider choice of the under utilised options based on midwifery care, and to change women's perceptions of birth.* This legislation required the amendment of five acts of parliament and nine regulations. Midwives were legally entitled to prescribe medicines commonly used in pregnancy; order routine laboratory tests; make direct referrals to consultants; and have access to public maternity hospital facilities on the same basis as general practitioners. They were also able to claim equal maternity benefit schedule fee-for-service (Pelvin, 1990; Donley, 1995). On the introduction of the Nurses Amendment Bill in Parliament, the Minister for Health, Hon, Helen Clark reiterated the words of the WHO definition of a midwife, stating:

> *a midwife is educated to give the necessary supervision, care, and advice to women prior to, and during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. The care that a midwife is qualified to give includes detection of abnormal conditions in mother and child ... The midwife has an important role in the prevention of complications, and achieves this through education of the woman, and her family within the wider community. She is qualified to work in any setting, be that in a home, hospital, or community* (Clark, 1990: 9).

The relevance of the changing paradigm in the provision of maternity care in New Zealand to the practice domain of Australian midwives remains to be reviewed. It does provide an example of change within a country influenced by similar historical and social ties as Australia.

2.7 The emerging domain of Australian midwives

Peters (1995) refers to the unifying effect of the international definition of a midwife, first adopted by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians in 1972, and later by the World Health Organisation (1976). Peters states that although the definition is quoted extensively, it allows for diversity, both internationally and within midwifery practice contexts. The broad sphere of practice encompassed by the definition has provided scope for midwives internationally to evolve what a midwife is, and what a midwife does, within each nation's maternity service.

Even though midwifery is moving towards meeting the established characteristics of a profession as listed by Flexner (1915) it remains subsumed by the nursing and medical professions. This is demonstrated explicitly in the Nurses Acts of the various states, with the definition of midwifery as a specialty of nursing (Nurses Act 1991-NSW; Nurses Act 1992-WA;), and the change from the Midwives' Regulations 1985 in Victoria to a Code of Practice for Midwives in Victoria, 1996, administered through the Nurses Board of Victoria.

Within midwifery practice various nursing models have been modified for use, without wide acceptance from practising midwives. At best they have provided a framework for curricula development, but midwives have seen it as an imposition of nursing models upon midwifery practice (Masoe, 1991: 198-209; Midgley, 1995). A search for research into the midwives' acceptance and use of the nursing process as a problem solving approach in practice was not fruitful.

Midwives, however, recognised the need to have a special body of knowledge (theory) on which to base their skills and services. They also realised that research into practice would continually expand this body of knowledge. This view was advanced by the ACMI with the development of the *Standards for the Practice of Midwifery* (1989). Thus midwives continued researching their practice and expanding their body of knowledge. Australian midwives have contributed to the international research into

midwifery care structures, processes and outcomes (Cochrane Collection, 1995). Midwives have also implemented research findings into their practices and discarded rituals that have proven to be ineffective (Alexander, Levy and Roch, 1990; Robinson and Thomson, 1989, 1991, 1994 and 1996).

Waldenstrom (1996) acknowledges the Australian midwives' desire to expand their sphere of responsibility and decision making, and to gain more respect for their professional knowledge. The overlap between obstetrics and midwifery, and the question of how much responsibility mainstream midwifery practitioners are equipped to undertake, remains crucial to any strategy for change. Waldenstrom refers to the changes during the last decades, such as:

> *the rapid increase in the use of medical technologies, increasing numbers of obstetricians, and the development from hospital based midwifery programs to tertiary level education... have made many midwives uncertain of their role* (1996: 8).

2.8 Summary

The uncertainties of professional identity and midwifery confidence are important issues for Australian midwives. Their sphere of practice and specific responsibilities within the diverse practice settings and models of maternity service provision need to be identified and analysed (Waldenstrom, 1996). Such an analysis is necessary if midwives are to change mainstream midwifery and expand the benefits of the midwifery model of care to childbearing women and their families within Australian maternity service settings.

The scope of the research presented within this literature review of midwifery practice has ranged from controlled trials and longitudinal studies to grounded theory methodology. There has been an emphasis on the international and national reports focusing on the role of the midwife in providing care within all maternity service models. The review provides a synthesis of the historical and contextual issues affecting national and international midwifery practice. Journal articles, texts, consumer focused literature on child birth, historical accounts and research findings have been assessed for the usefulness in contributing understanding to the issues affecting the practice domain of Australian midwives.

It is within this context of uncertainty and change that this case study on the Australian midwives' practice domain has been undertaken. It is an essential requirement for the successful implementation of change that there be an understanding of the actuality of practice of the players involved. The domain of Australian midwives' practice can best be determined through its correlation to the ACMI (1989) *Standards for the Practice of Midwifery.* There is also a need to identify and explore those factors that affect the full assumption of the role of the midwife.

CHAPTER THREE

METHODOLOGY

3.1 Introduction - a sociological perspective

This study has drawn upon theory and techniques from the discipline of sociology to explore and explain the practice domain of Australian midwives. The assumption has been made that midwifery is a profession. Australian midwives practise in close association with the medical and nursing professions. In many instances these professions are seen to overlap. The apparent duplication of roles between midwives and doctors in the care of childbearing women and their families has resulted in disputes over occupational territory. Less conspicuously, the close links between the nursing and midwifery professions have seen the subsumption of the latter by the nursing profession. Within the diverse practice settings of maternity care throughout Australia the complexity of role delineation is compounded. This study identifies and discusses the inter-related factors influencing the role and sphere of practice of the midwife, and the status of midwifery as a profession, from a sociological perspective.

The study of professions in Australia took a critical direction during the 1970's. The definition of *professional* and *professions* departed from the traditional dictionary definitions highlighting the three professions of divinity, law and medicine, and expanded to include numerous occupations. These occupations claimed a unique body of knowledge and specialised skills, valued by society and which legitimated their recognition as a profession (Boreham, Pemberton and Wilson, 1976).

Pemberton and Boreham (1976), called for a reorientation of theory and research into the study of professions. A conflict approach was considered to provide a more balanced picture of professions today than the functionalist concentration on order and consensus. The professions were viewed as being in a state of crisis. This crisis referred to the knowledge base of the professions and the crisis of professional practice in day-to-day affairs. Methodological innovation in the study of professions, and a willingness to tackle the macro sociological issues, were considered imperative if an understanding of professions was sought. It was argued that case studies involving a variety of data collection methods could accurately reflect first hand

knowledge of a profession. They could also help in the analysis of intra-professional disputes. Furthermore, case studies could point to reasons for failure to meet their stated professional goals; and failure to address client initiated charges of class biased inequities in the provision of their services.

There are three essential levels of analysis linking the macro-social analysis of health and illness in society. At the individual level, the phenomenological perspective contributes towards understanding the individual experience of the consumer of health services. The social level of analysis is concerned with cultural categories of sickness from the sociological perspective of roles, norms and deviance. The societal level concentrates on the politics of health and the study of health care systems, from an economic-political perspective of illness (Turner, 1987). The sociological perspective influencing the methodology chosen for this analysis of the practice domain of Australian midwives has focused on the role of the midwife and the actions and interactions occurring within maternity services. An action analysis approach, using a case study design, has enabled the development of a conceptual paradigm explaining the relationships between the complex sociological factors influencing the practice domain of the Australian midwives.

3.2 An action analysis approach

The emphasis on action, and the meanings actors attach to their own and others with whom they interact underpins the action analysis approach to organisations developed by Silverman (1970). Silverman argues that *explanations of social actions must arise from definitions of the situation and purposes of the actors.* He sees it as vitally important that the different perceptions of actors of their situations, characteristics, and dominant role systems, be understood. Only then is it possible to come to grips with the subjective meanings attached to typical actions, and their intended and unintended consequences for other actors.

Silverman promotes the action approach as a method of analysis rather than a theory. It offers a frame of reference from which questions can be derived about the social life within any organisation. He concedes that only empirical studies can provide the answers to the questions raised, but the data can be referred back to a consistent analytical structure.

Action analysis, within the framework suggested by Silverman, tackles both the *micro* problems of the orientations and behaviour of particular actors, and the *macro* problems of the patterns of interactional relationships. What is called the life world of actors by Habermas (1979) is described by Silverman as re-interpretation of the meanings of the actors' common sense in terms of the meanings of sociology, or an unmasking of the assumptions behind the typical acts upon which the life world of the actors is based.

Bauman (1992) speaks of the special place occupied by common sense in the academic discipline of sociology. The knowledge we require to live our everyday lives, often deeply immersed in daily routines, is common sense knowledge. Yet we seldom pause to consider the meaning of our actions. Before sociologists started theorising about human actions and interactions, they were already objects of commonsensical knowledge. They had been given meaning and significance by the actors themselves.

Giddens (1992) also discusses the importance of common sense to our day-to- day activities. He refers to common sense as mutual knowledge, and knowledge that is needed to *go on* in these activities. Giddens states that *to be able to generate veridical descriptions of social activity means in principle being able to go on in that activity, knowing what its constituent actors know in order to accomplish what they do* (Giddens, 1992: 363). He sees the implication of this point as all social analysis having an hermeneutic or ethnographic moment, which has been dissolved in traditional mainstream social science. *In order to generate valid descriptions of social life the observer must employ the same elements of mutual knowledge used by participants to "bring off" what they do* (Giddens, 1992).

Silverman (1970) refers to the contribution of the grounded theory methodology propounded by Glaser and Strauss (1967) to re-interpreting the meanings of common sense in terms of the meanings of sociology. Silverman sees it as a view of the research process which complements the action analysis approach he proposes. He agrees that the potentialities of research have been limited by a concentration on testing and verification of theories, and a failure to recognise the way research can be used to generate theory. Rather than forcing data into preconceived reality, categories which participants use to order their experiences should guide the generation of theory grounded in *life world* data.

The grounded theory approach to qualitative data analysis uses a systematic set of procedures to inductively develop a grounded theory about a phenomenon (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss and Corbin, 1990; Glaser, 1992). Strauss (1987), and Strauss and Corbin (1990) provide procedures and techniques of a more prescriptive nature than earlier writings.

The logic of grounded theory stated by Glaser in *Theoretical Sensitivity* (1978) and reiterated by Glaser (1992), is contained in two questions. They are: *What is the chief concern or problem of the people in the substantive area, and what accounts for most of the variation in processing the problem? And secondly, what category or what property of what category does this incident indicate? One asks these two questions while constantly comparing incident with incident, and coding and analysing. Soon categories and their properties emerge and are of relevance to the processing of the problem* (Glaser, 1992: 4).

The arguments put forward by Glaser against the forcing of data into preconceived conceptual frameworks balance the level of prescription introduced in what he refers to as Strauss's last two books (Strauss, 1987 and Strauss and Corbin, 1990). The techniques illustrated by Strauss and Corbin have been helpful throughout data analysis and the development of a conceptual paradigm in this present study. In particular, they have contributed towards the theoretical density of categories, through exploring the range of conditions affecting the dimensions of the properties of each category, and the consequences resulting from actions and interaction in this present analysis of Australian midwives' sphere of practice. Most importantly, they have assisted in moving beyond description of the practice of Australian midwives, to providing explanation. As Glaser advises in the following excerpt: *What a man in the know does not want is to be told what he already knows. What he wants is to be told how to handle what he knows with some increase in control and understanding of his area of action* (Glaser, 1978: 13).

3.3 Design of the study

By focusing on the practice of Australian midwives within the context of their practice settings this research used a case study design to explore, describe and interpret the midwives' sphere of practice.

For the purpose of this study Australian practising midwives were nominated

as an entity or case selected from other maternity care providers. Their particular contribution towards the care of childbearing women and their families was analysed through their actions in the provision of care, as well as their interactions with consumers and health professionals within their practice settings. This *bounding* of a group has been described as *an examination of a specific phenomenon such as a program, an event, a person, a process, an institution, or a social group* (Merriam, 1988: 9).

By concentrating on the practice of Australian midwives as a case, this study aimed to provide meaning to the actions and interactions that determined the sphere of practice of these midwives, and to provide a holistic description and explanation of Australian midwifery practice.

The analytical approach suggested by Silverman (1970: 154) was adapted to generate relevant questions to structure initial data gathering in this study of Australian midwives' practice domain. These were as follows:

1. The nature of the role-system and pattern of interaction within the maternity care team, its historical development, and the extent to which it represents the values of the team members;
2. The nature of the involvement of the maternity team members and the characteristic goals they pursue;
3. The maternity team members present definitions within the organisation and their expectations of the likely behaviour of others;
4. The typical action of midwives and other team members and the meanings they attach to their actions;
5 The effects of intended and unintended actions on the role systems within which the maternity team members interact, and
6. The effect on the role system of the changing knowledge outside the organisation e.g. the changing expectations of consumers; political and economic changes.

The characteristics considered essential properties of the case study have provided the holistic approach required for such a research design. Merriam (1988: 11) has summarised these characteristics from a review of case study definitions as: particularistic, descriptive, heuristic and inductive.

In this study the *particularistic* characteristic was the focus on the Australian midwives as they practised within the diverse practice settings within Australia. Their interactions with other health professionals providing maternity services were described and discussed but the focus remained at all times on the Australian midwives' perceptions of their actions and interactions within maternity care settings. International influences on midwifery practice were also discussed, again with the focus remaining on the *bounded case,* which for the purpose of this descriptive, evaluative and explanatory study was the *Australian Midwives' Practice Domain.*

The *descriptive* characteristic of this study was embedded in the sources of data. Demographic, numerical, and textual data were interpreted from a sociological perspective of contextual settings, conditions, cultural norms and mores, community values and deep seated attitudes (Guba and Lincoln, 1981).

The *inductive and heuristic* qualities of this study relied on a *grounded theory* approach to data collection and analysis (Glaser and Strauss, 1967). At the outset of the study, exploratory data from a review of maternity services documentation and a pilot study of a selected group of midwives, provided tentative direction for the research. Early direction was also guided by an action analysis conceptual framework (Silverman, 1970) allowing the sociological interactionism paradigm to provide a philosophical foundation to guide data collection and analysis. The use of *theoretical sampling* (Glaser and Strauss, 1967) to build on the concepts identified at the beginning stages of the study, inductively built on emerging theoretical categories *grounded* in the descriptive data from the context of the midwives' practice domain.

The Conditional Matrix presented by Strauss and Corbin (1990: 163) as a set of circles, one inside the other, with each level corresponding to the world around us, was used as a tool for organising data analysis and the development of the conceptual paradigm. The action pertaining to each phenomenon under study was depicted as the innermost circle. This was surrounded by the interaction between the actors involved in the phenomenon. Conditions affecting the action/interaction were traced, both inductively and deductively, through the levels of collective groups, sub-organisational to organisational levels, community, national and international levels. Specific conditional factors within each level were analysed according to their impact on the chosen area of investigation. The conditional path between levels was traced

back and forth as the relevance of concepts emerging from study data were linked throughout the levels. This linking of conditions and consequences of actions/interactions was verified through the data and had a direct or indirect effect on the study phenomenon.

While using the case study design to arrive at a comprehensive understanding of the group under study this methodology can also be used to develop more theoretical statements about regularities in social structure and process. It is a research methodology that can both test and build theory and include quantitative and qualitative data collected through random or purposive sampling (Merriam, 1988).

Ultimately justification for the use of a case study design rests on its acceptance by the case being studied. It should be seen as being pragmatic; producing knowledge that is understandable and applicable, and which the subjects of the study can continue to generalise to their experiential settings and circumstances (Merriam, 1988).

These multiple approaches to research of a particular case is the triangulation of method explained by Denzin (1970). The case study design provided the versatility and flexibility required in the collection and analysis of data to meet the purpose of this study which was:

to identify the actual domain of midwifery practice in Australia, according to the Standards for the Practice of Midwifery (ACMI, 1989), and to determine and explain those factors affecting the enactment of the full potential role of the midwife.

3.4 Case study population

The case population being studied was midwives registered to practise throughout Australia. This included the 61386 midwives registered with the Nurses Boards of Australia during the period June 1991 to June 1994. Figure 1 (p. 45) shows the distribution of registered midwives throughout Australia. This information was provided by the states' Nurses Boards in October, 1994. (Information was not available from the Australian Capital Territory).

The target population for the survey was all currently registered to practise midwives within the states of New South Wales, Victoria and Western Australia. Information obtained from the Nurses Registration Boards of each state estimated

this to be 39466 midwives as of June, 1991. The figure had increased to 40440 by June 1994. The midwives from these three states were selected as being geographically representative of midwives practising within settings similar to those throughout Australia.

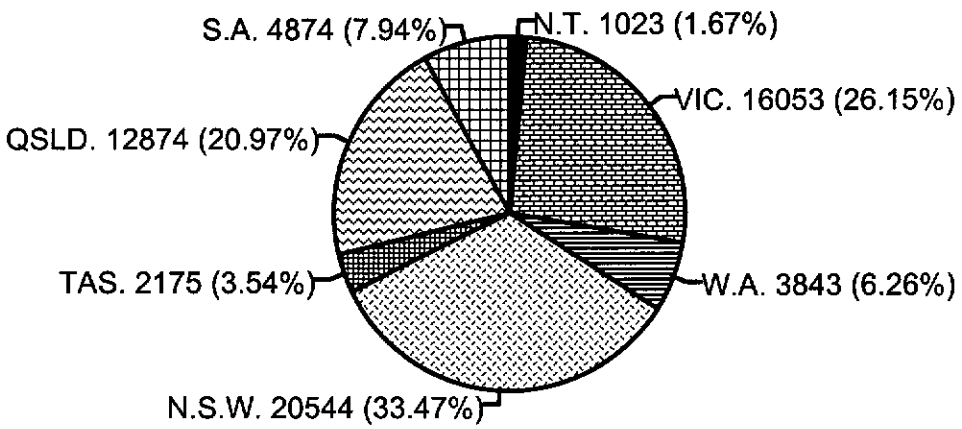


Figure 1: Distribution Of Registered Midwives Throughout Australia (n=61386).

Although case study findings, in general, make no claims to be representative they can produce themes defining types of social behaviour and generating hypotheses which can be tested against other data or in later studies (Haralambos and Holborn, 1990). This study combined quantitative and qualitative data collection and analysis within the case study design. This allowed descriptive, quantitative data obtained from the representative survey sample of practising midwives, to enrich the conceptual paradigm that emerged from the rich descriptive data obtained through in-depth interviews and fieldwork. The paradigm was built around a core process identified as integrating contextual categories and their consequences for midwifery practice. The paradigm was enhanced through the contribution of the large, randomly selected sample of practising midwives (n=1754) who provided quantitative and qualitative data supporting the findings of the smaller purposively (and theoretically) selected sample of midwife interviewees (n=75).

Inductive and deductive analysis was used to provide mutual support to both quantitative and qualitative survey and interview findings. Throughout the collection, analysis and interpretation of qualitative data, the findings of the quantitative survey were used to identify factors affecting midwives' practice. This was used to guide the search for more descriptive data to explain and add meaning to the survey findings.

Together these methods strengthened the reliability, consistency and validity of the case study findings (Merriam, 1988: 127).

3.5 Sample for the pilot study

A pilot sample was required to test the content validity of the questionnaire designed for the survey. This sample of 30 practising midwives was a sample of convenience. Midwives working within the South Metropolitan Health Area in Perth, Western Australia participated in this pilot study. They were asked to respond to the questionnaire that had been designed with input from a selected panel of midwives (Appendix 1), using information obtained from policy and procedure manuals, job descriptions in current use in Western Australian health settings, current texts and the Australian College of Midwives Inc. *Standards for the Practice of Midwifery* (1989).

3.6 Sample for the questionnaire survey

A 10 per cent sample was randomly selected from the register of practising midwives for the states of New South Wales, Victoria and Western Australia. The Nurses Boards of each of these states were requested to use recognised random selection techniques to determine those midwives who would participate in a questionnaire survey. This resulted in a sample size of 3860 practising midwives.

Table 1 Responses to Postal Questionnaires (completed 31/12/93)

	NEW SOUTH WALES			V I C T O R I A			WESTERN AUSTRALIA		
	Sent	Ret'd	%	Sent	Ret'd	%	Sent	Ret'd	%
First Posting	2000	897	44.85	1500	677	45.13	360	164	45.55
Second Posting	1000	92	5.3	810	239	29.50	190	72	37.89
Total Responses per State		989	49.45		916	61.06		236	65.55

Total number of responses 2141 Overall response rate 54.45%

Of the 3860 midwives selected to receive a survey questionnaire the final response rate was 55.46%, a total of 2141 (Table 1, p.46). Of these 2141 respondents, 387 took advantage of options offered at the commencement of the questionnaire to state their reasons for not wanting to complete the full questionnaire. The options and response frequencies are listed in Table 2 below. Exclusion of the 387 partial responses gave a 45.44% response rate.

Table 2 Reasons Given by Midwives only Completing Page ii of Postal Survey Questionnaire. n = 387

	Frequency	Percentage
Returned by Proxy	29	7.5
Too Busy	54	14.0
Not Interested	28	7.2
Don't Want to be Involved	31	8.0
Don't Care About Midwifery	40	10.3
Retired too Long Ago	27	7.0
Out of Midwifery	133	34.4
Unaware of Current Situation	22	5.7
Lack Experience	23	5.9
TOTALS	387	100.0

The final total of survey respondents included in the sample of midwives registered to practise within the states of New South Wales, Victoria and Western Australia was 1754. A further distinction was made through the responses to the questionnaire. Those midwives who were registered to practise but who had not done so for the past 5 years (from the time the questionnaire was received during May to September, 1993), were asked to respond to Section One only of the questionnaire. Those who had practised as midwives during the past five years were asked to fill in all sections that applied to their areas of practice. This resulted in two groups being formed i.e. 882 (50.3%) who had practised in the past 5 years (EP5 group), and 864 (49.3%) who had not (NEP5 group). There were 8 missed responses to the question. Further details of the survey sample are given in Chapter Four of the study.

3.7 Sample for the in-depth interviews

Purposive sampling leading on to theoretical sampling (Glaser and Strauss, 1967) was used for the selection of these practising midwives. The executive members of the Australian College of Midwives Incorporated (ACMI) for the states of New South Wales, Victoria and Western Australia were asked to nominate midwives working in the areas of midwifery education, clinical practice and management whom they considered knowledgeable and *expert* in specific practice settings. This provided the initial contacts in the practice settings. As fieldwork progressed and qualitative data analysis was ongoing, other midwives were recommended by their colleagues as being well informed on particular aspects arising from the fieldwork data. As a result of this theoretical sampling a total of 75 midwives: 20 from New South Wales, 30 from Victoria and 25 from Western Australia were interviewed before *theoretical saturation* (Glaser and Strauss, 1967, Corbin and Strauss, 1990) was reached. Theoretical saturation was considered to have been reached when there were no new instances of actions/interactions occurring within specific contexts (Field and Morse, 1985). The large sample size was influenced by the diversity of practice settings and the contextual impact of the settings on midwifery practice.

3.8 Procedure

A triangulation of methods (Denzin, 1970) was used for data collection. This included:

1. a pilot study to assess the suitability of the questionnaire as a data gathering tool;
2. a questionnaire survey of a randomly selected sample of practising midwives from the three nominated states;
3. thematic content analysis of open ended questionnaire responses to guide interview planning, and
4. in depth interviews conducted with midwifery nurse managers, educators, and clinical practitioners from the same three states. These midwives were initially selected by the College of Midwives Executive within each state on the basis of being experienced midwifery practitioners within specific practice settings and their spheres of clinical practice, management or education. As data analysis proceeded theoretical sampling was used to reach

theoretical saturation of emergent categories.

The study was conducted in the following three stages:

3.8.1 Stage 1.

(a) Review of Documentation

Data were collected from regulations, policies and procedures, standards for practice, and job descriptions, controlling midwives' practice. This information was used by the researcher to develop a draft questionnaire. This was evaluated by a selected panel of midwifery practitioners, as a tool for collecting survey data from practising midwives. Several draft copies were developed with input from the panel before it was agreed to trial the revised questionnaire in a pilot study.

(b) A Pilot Study

The convenience sample of 30 midwives in practice settings in Perth was asked to complete the questionnaire and to provide criticism and suggestions to improve the questionnaire. Suggested changes were discussed with the selected panel of midwives. The final questionnaire, incorporating the changes suggested by the practising midwives who had participated in the pilot study, finally met the approval of the panel as a data gathering tool.

3.8.2 Stage 2.

Questionnaire Survey

A survey of midwives throughout the states of New South Wales, Victoria and Western Australia was conducted using a descriptive and exploratory design. These three states were chosen for the survey as they reflected the diverse practice settings that are found throughout Australia. The structured questionnaire (Appendix 2) included some open ended semi structured questions designed to provide practising midwives the opportunity to address the stated research questions and provide data required to meet the objectives of the study.

The questionnaire addressed antenatal, intrapartum and postnatal areas of practice in primary, secondary or tertiary health care settings. Each midwife was requested to answer questions related to any area or setting in which they had practised during the last five years. Open ended questions provided opportunity for

in-depth expression of midwives' views related to their practice domain. Comparative groups comprised of midwives in clinical practice, midwives in education, and midwives in management, were self selected through their questionnaire responses to categorisation of their main area of practice.

Midwives who were registered to practise but had not done so for the last five years (NEP5 group) were asked to express their views on matters other than current clinical task analysis. To exclude these registered midwives from the study would have created a bias as it was important to establish why these midwives were not currently practising and to acknowledge that as registered midwives they could have applied for employment as a practising midwife at any time.

3.8.2.1 Measuring instrument

The questionnaire elicited information regarding:

1. (a) midwives actual responsibilities for care during pregnancy;

   (b) the extent to which midwives perceived their practice reflected the sphere of practice for care during pregnancy as stated in the *International Definition of a Midwife* (WHO, 1976).

   (c) midwives views of social, political, cultural and educational factors affecting their ability to provide antenatal services that met the process and outcome standards of the Australian College of Midwives Incorporated (1989). These standards were based on *the International Definition of a Midwife* (WHO, 1976).

2. (a) midwives actual responsibilities for care during all stages of labour;

   (b) the extent to which midwives perceived their practice reflected the sphere of practice for care during all stages of labour as stated in the *International Definition of a Midwife* (WHO, 1976).

   (c) midwives views of social, political, cultural and educational factors affecting their ability to provide intrapartum services that met the

process and outcome standards of the Australian College of Midwives Incorporated (1989), based on the *International Definition of a Midwife* (WHO, 1976).

3. (a) midwives actual responsibilities for care of the mother and baby following birth;

(b) the extent to which midwives perceived their practice reflected the sphere of practice for postnatal care as stated in the *International Definition of a Midwife* (WHO, 1976).

(c) midwives views of social, political, cultural and educational factors affecting their ability to provide postnatal services that met the process and outcome standards of the Australian College of Midwives Incorporated (1989), based on the *International Definition of a Midwife* (WHO, 1976). [See Appendix 3]

3.8.3 Stage 3

Fieldwork and In-depth Interviews

A thematic content analysis of the open ended responses to the survey questionnaire, discussions with the panel members, and consideration of the diversity of practice settings, guided the initial settings to be visited for interviews with midwives. Structural categories were evident at the outset and these were used to organise fieldwork and to guide the in-depth interviews. The three main structural categories were: the geographical, physical setting; the area of clinical practice; and the model of service delivery.

The Australian College of Midwives' executive committees for New South Wales, Victoria and Western Australia were asked to nominate midwives practising within these structural categories. These 45 midwives formed a core group of 15 midwives within each of the three selected states with whom interviews were held. Practice settings visited and the number of interviews conducted within each setting are listed as Appendix 4. Fieldwork included observing the practice settings of those midwives being interviewed and examining policies and procedures manuals used in these settings.

As interviews progressed within each state, information gained from the

different settings and clinical practice areas, that used various models of service delivery, led to further interviews to clarify and add to the data being gathered. Where necessary, phone interviews were held to follow through on interviewees who could not be revisited. This use of purposeful selective interviewing, combined with theoretical sampling, was pursued until data saturation was reached.

Field notes were kept as the interviews were in progress. These enabled an *on the spot* beginning analysis of the interviews to take place. Data were recorded within the context of the three structural categories established i.e. practice setting, area of clinical practice, and model of service delivery. Field notes included notations made from observations at the time and place of the interviews. They included ideas generated from both observations and interviews thus linking emerging interrelationships between settings and midwives' actions/interactions. For instance:

Date 12/5/93 P------- Hospital. Interviewee D------

D's role is Staff Development for the whole hospital. Her interest was obviously midwifery - as stated during the tape recorded session. I was shown around the maternity section and noted how closely the delivery rooms reflected the alternative birthing suite model referred to by R--- during her interview with me yesterday. I also saw the Vietnamese interpreter speaking with a woman in labour (refer to R's interview). D--- gave me a copy of the last three months stats (sic) - confirming the verbal information I had been given. This is the only hospital I've visited so far where the philosophy of the alternative birthing suite model is so obvious throughout the labour ward and delivery rooms. D----- confirmed what I had been told by R---- yesterday that the specialist obstetrician demonstrates a lot of

trust towards the midwives. All the public patients are seen first by a midwife and the obstetrician only called if the midwife is concerned about something.

D---- also confirmed the extended role described by R------.- Midwives were certified competent to suture and to insert Ivs. (sic) Again this is a first in the settings I've been to so far, but D--- says it is not uncommon in hospitals with a greater percentage of public patients.

Both interviews at P----- hospital, and the policy and procedure manual I was able to look through suggest that a lot depends on the relationships between the hospital obstetrician and the midwives. Not just in relation to the extended role, but also for the birthing outcomes for the women. Perhaps this has more effect on the midwives' practice than the actual setting or model of care?

Tape recordings were made of all interviews. Although the interviews were unstructured an opening comment was consistently used to focus the interviewee on their role within their particular practice setting. This provided a recorded context for each interview to supplement notes taken during field observations.

Once initiated the recorded interviews took the direction chosen by the interviewees. Guidance from the interviewer took the form of probing questions arising from the data flow. There was no reluctance by midwives to talk freely about their practice or to express their perceptions of the midwife's role. It was often during the interview that a reference would be made to another midwife they felt could give further insight into a particular aspect they were discussing. This openness and willingness to share information allowed the researcher to access other midwives

perceived by their peers to be *experts* in particular areas of practice. These referred interviewees were able to clarify ideas and tentative themes or specific issues that were emerging from the interview data.

Interviews were ongoing throughout data analysis with contact being kept with some midwives for the duration of the study. This enabled the researcher to verify interpretation of the meanings that midwives attached to their actions of providing midwifery care, and their interactions with consumers and other maternity care providers. Follow through phone interviews were also conducted with midwives who indicated their interest in particular aspects of practice in the survey questionnaire.

3.9 Data analysis

The case study design allowed full utilisation of data collected through triangulation of methods. Focus on Australian midwifery practice as a defined entity integrated the four research questions, with data from all sources being analysed simultaneously and continuously.

The *International Definition of a Midwife* (WHO, 1976) and the *Standards of Practice* (ACMI, 1989) provided the benchmarks on which the survey responses were measured. Defined process standards related to midwifery practice allowed comparisons to be made between ideal and actual practice. This quantitative evaluation guided further data analysis of factors identified as affecting practice processes and outcomes.

The Statistical Package for Social Sciences (SPSS) (Norusis 1992) was used for quantitative data analysis. Data from the two sample groups, midwives selected by purposive and theoretical sampling (n=53 of the 75 interviewees who also completed a questionnaire) and midwives randomly selected to participate in the survey (n=1754), were entered in different files and held separate throughout the analysis procedures.

Midwives' written comments in response to open questions in the survey questionnaire provided explanatory data. A thematic content analysis was used to analyse this data. Detailed descriptive data were transcribed to the Ethnograph (Seidel, Kjolseth and Seymour, 1988) for coding and sorting, which assisted in the development of categories. Code words were mapped by entering the beginning and

ending line numbers of the context of the coded concept. This facility of the Ethnograph enabled clusters of similar concepts to be retrieved, within the context of the coded phenomenon. Categories were developed from the clusters of similar concepts. The frequency of the occurrence of the code words indicated the prevalence of the properties of the concepts contributing to the formation of categories. This allowed full utilisation of the qualitative written data from the randomly selected sample of midwives (n = 1754) which finally assisted in the development of the conceptual paradigm. The following example illustrates the line numbering function of the Ethnograph used to map code words for retrieval using the search function:

c3852: Id.

+Section 3

Comments While so employed, I worked	1709	*setting*
mainly in the nursery and had limited	1709	*specialise*
experience working in the antenatal	1710	*mwprac*
ward or labour ward. I also worked	1711	*shifts*
night duty, so that most health	1712	*isolate*
professionals were not on duty. But	1713	*antenatal*
there were occasions that I worked in	1714	
the wards but most of the	1715	
medical/obstetric history had been	1716	*fragment*
obtained on their arrival in labour	1717	
ward prior to admission to ward as an	1718	
antenatal patient.	1719	

The retrieval of data using identifying code words facilitated the sorting of concepts, and clusters of concepts, into categories. These categories were then sorted into larger categories with common properties. For instance, the clusters of concepts contributing to consumers' influence on the practice of midwives contributed to the development of sub categories classified as: lack of recognition of the role of the midwife; medical dependency; lack of information regarding choices; social factors, and historic and cultural factors. The same process of grouping clustered concepts into sub categories was followed, leading to the emergence of the major categories.

The development of the core category occurred as the interactions between the major categories were analysed using the same procedure of clustering concepts identified as either facilitating or limiting midwives' practice opportunities within the different contextual conditions and situations.

The complexity of the interwoven web of facilitators and barriers to the midwives' practice domain is depicted in the three schema presented in the findings (p. 198; p. 200, and p. 266). These schema were developed cumulatively throughout the process of data analysis. This allowed a sense of order to emerge as incoming data was added to the building of categories, or the forming of a new category.

Throughout the data collection phase of the study (May, 1993 to December, 1994) data analysis proceeded. Information obtained through the in-depth interviews and through non participant observation during fieldwork was constantly reviewed to seek out themes and comparisons occurring within the different practice settings. Following the recording of interviews on tape an *interview log* was devised to assist in ordering the data (Merriam, 1988: 84). The researcher and research assistant listened to the tapes independently making notes on important statements, words and ideas. These notes were coded to the tape counter so that the information could be quickly accessed for transcription and analysis. The interview log was entered to the Ethnograph for mapping using code words. This ensured all 75 interviews were coded for retrieval as data analysis proceeded. An illustration of the procedure appears in the following section from an interview log:

Robyn : - Adv Practicing Midwife

\+ - Intrapartum. P-------- Hospital. NSW

010 - Labour Ward specific - most	*setting, rotate*
staff rotate - core groups each area.	*core staff,*
025 - CNS role(NSW) and career	*staffing*
structure.	*mwroles*
065 - setting and services. L2 nursery	*setting*
- career structure continued.	*specialise*
105 - effect of rotation on job	*rotate*
satisfaction.	*jobsat*

114 - Clinic patients - 80% of 1700 deliveries.	*public deliver*
120 - Comparison between ---------- Shire and P---------- - Private/insured and Public.	*pub/priv*
125 - Patient questionnaires.	*consumer*
145 - Multicultural aspects - interpreting Services.	*multicult interpret*
166 - Clinic patient procedures, public and private.	*extrole pub/priv*
180 - Continuity - reference to Newcastle and Westmead and Caroline Flint`s model. (continued ...)	*continuity teammw model*

Using the interview log as a guide, interviewees were nominated as either *elite* i.e. having specialised information regarding specific practice areas, or, *key informers* (Merriam, 1988). Key informers have been described by Merriam (1988) as those who are able to reflect on the culture and articulate to the researcher their understanding of what is taking place. As such, they are able to adopt the stance of an investigator and to some extent guide the analytical process. Tapes of the interviews of key informants were fully transcribed and coded to the Ethnograph. This involved comparing across all 75 interviews entered into the interview log with the code notes of the two independent data analysts. In addition fifteen interviews were fully transcribed, and the Ethnograph (Seidel, Kjolseth and Seymour, 1988) used to store and retrieve all data for qualitative analysis. The approach of constant comparison was used to cluster together concepts with similar properties and dimensions from the interview log and the fully transcribed interview data. These clusters were then coded and entered to the numbered Ethnograph. Retrieval of data with similar properties and dimensions was assisted by the search function of the Ethnograph as codes were mapped by their location on the numbered lines. (See Appendix 5 for examples of coded sections using the Ethnograph).

Throughout the process, data collection was guided initially by the findings of the survey but as more in-depth data was obtained through the interviews more integrated and intricate patterns emerged, thus further directing data collection. Data collection from interviews ceased when it was considered that saturation had occurred. This was recognised when no new categories were emerging that were contributing to further understanding of the midwives' practice domain (Field and Morse, 1985). Data analysis, working towards theoretical saturation where no new or relevant properties and dimensions of each category emerged, was continuous throughout the study. Midwives were recontacted for further information and clarification of data as the search for the meaning of the actions and interactions occurring between and within categories continued.

Paradigm development proceeded as the interactive processes linking all categories to the core category and the resulting outcome were discussed within a sociological paradigm. The *Conditional Matrix* (Corbin and Strauss, 1990:163) provided a conceptual framework that facilitated the factors affecting the actions of midwives to be analysed. International, national, community, organisational, group and individual interactions were analysed from contextual, conditional and consequential perspectives.

3.10 Reliability and validity

The reliability of the questionnaire used for the collection of data from the randomly selected sample of midwives registered to practice throughout New South Wales, Victoria, and Western Australia, was trialed through a pilot study. This was conducted amongst midwives known to the researcher and to the selected panel. The findings were compared with organisational statistical data, policy and procedure manuals and job descriptions within different practice settings.

The questionnaire was also monitored for reliability and validity during the field work visits and interviews with midwives throughout the three participating states. Following in depth interviews, midwives in diverse practice settings (Appendix 4) were invited to respond to the questionnaire, giving their identification and their practice setting. There were 53 midwives who provided this identified information through the questionnaire, in addition to being interviewed in their work place settings. This allowed comparisons to be made between multiple sources of

data, including direct observation by the researcher in the practice settings. It also provided quantitative data that was entered into a separate SPSS file for comparative analysis with the data from the randomly selected midwives taking part in the questionnaire survey.

Techniques for ensuring reliability in qualitative research focus on establishing the dependability and consistency of the results obtained from the data (Guba and Lincoln, 1985: 228). This study has addressed the three key issues affecting the internal validity, or dependency and consistency, of the qualitative findings as suggested by Merriam (1988: 172):

1. The investigator's position: The position of the researcher in relation to the case, Australian midwives, has been outlined in the personal profile submitted as Appendix 10. Assumptions made by the researcher have been stated. The basis for the selection of midwives participating in the interviews has been explained in the study methodology. This has included disclosure of settings where interviews and field work were conducted (Appendix 4).
2. Triangulation: Multiple methods have been used for data collection and analysis.
3. An audit trail has been outlined in this methodology chapter that would enable replication of the study (Goetz and Le Compte, 1984: 216).

The sorting of qualitative data into categories with defined properties and dimensions was validated through consensus between the researcher and a midwife research assistant (Appendix 6). Properties and dimensions of categories were identified independently during the initial coding. The consistency and internal validity in the identification of categories was established through clarification of concepts with practising midwives working in similar settings to those midwives providing the initial data. This clarification procedure was followed throughout until there were no further new properties to the categories emerging from the data.

While generalisability is not a primary concern of case study research it can be strengthened as external validity is established. In this study the multiplicity of data collection and analysis methods have increased the external validity of the case study findings. This has been achieved through:

1. Cross-site and cross-state data collection and analysis.
2. Establishing the typicality of the case through the use of comparative data, enabling users to relate the findings to their own situations.
3. Providing excerpts of rich, thick description, allowing the reader the opportunity to judge the basis for transferability of the findings (Guba and Lincoln, 1955: 124-125).

Preliminary findings were presented to midwives attending state and national conferences and through articles in midwifery newsletters (Cullen, 1994; Cullen, 1995). A report for the Commonwealth Department of Human Services and Health (Cullen and Martins, 1996) was circulated to state health departments; state branches of the Australian College of Midwives Inc., and to members of the midwifery panel and other midwives expressing their interest. These oral and written presentations provided midwives with opportunities for wider comment on the findings, and their endorsement of the case study's relevance to their practice.

3.11 Limitations of the study

This study aimed at describing the practice of midwives throughout the diverse maternity service settings in Australia. Only three of the Australian states were selected for the survey, interviews and fieldwork. Although the midwives practising in these states were considered representative of the Australian population of midwives, it is acknowledged as a limitation. This is in terms of the generalizability of the findings as there may be unidentified differences between the selected states and the remaining five states.

While this case study has utilised both quantitative and qualitative research methodologies, the philosophical underpinning of the study is to arrive at an understanding of midwifery practice within Australian settings. There is an emphasis on descriptive data to address the first two research questions of the actual domain and role of the Australian midwife. This has resulted in the use of descriptive rather than hypothesis testing statistics. Quantitative data has been presented in this manner to provide a demographic, numerically descriptive data base of midwives and their practice, and to identify the perceived issues affecting midwives' practice. The questionnaire survey is therefore exploratory rather than theory testing. The value of the numerical data obtained through the questionnaire

survey is descriptive rather than explanatory or prescriptive. It has provided the factual data base to support the conceptual paradigm developed through the qualitative data of the in-depth interviews.

The contribution of observational fieldwork has been limited to increasing the understanding of data gathered through the survey questionnaire and in-depth interviews. The actual clinical practice of midwives was not analysed from these observational field notes.

3.12 Confidentiality and ethical considerations

An addressed self sealing envelope was provided for the personal return of each questionnaire. A coding system was used to allow for follow up on non respondents. The coding system was not released to anyone other than those directly involved in the research. The right of the respondent to anonymity was respected at all stages of the research. Names and addresses obtained from the Nurses Registration Boards were not used for any purpose other than sample selection and questionnaire distribution. Following data collection and analysis the names and addresses from Victoria were destroyed. The Nurses Boards of Western Australia and New South Wales did not release the names and addresses of any midwives. All correspondence with the midwives in those two states was conducted through the Nurses Boards.

Midwives participating in the interviews consented to the tape recording of their interviews. Anonymity was respected throughout data analysis and presentation. Tapes were stored securely and with access limited to the researcher and research assistants. Hard copies of all data will continue to be held securely for 5 years after which they will be destroyed. All participating midwives gave permission for direct quotes to be used in the study.

The study proposal was submitted to the Ethics Committee of Curtin University of Technology and received their approval on an ongoing basis throughout the duration of the study (Appendix 7).

CHAPTER FOUR

FINDINGS - DESCRIPTIVE

4.1 Introduction

The study findings are presented in four chapters addressing the research questions of:

1. What is the actual role of the midwife in Australia in providing obstetric and neonatal care?
2. What are the discrepancies between the Australian College of Midwives Incorporated (ACMI) stated sphere of practice of a midwife and the actual role demonstrated by empirical data?
3. What are the facilitators and barriers to the enactment of the full potential role of the midwife as defined by the ACMI?
4. What action / interaction can midwives take to enable them to practise to the full extent of their defined role?

This chapter provides descriptive data about Australian midwives and their practice. It addresses the first research question on the actual role of the midwife in providing obstetric and neonatal care within the diverse practice settings throughout Australia. It also provides the background required to support the evaluative and explanatory findings presented in the following chapters.

4.2 Survey respondents - demographic data

Demographic data is presented at the outset of this chapter to provide a profile of Australian midwives and their practice settings.

4.2.1 Age

The majority of midwives who responded to the questionnaire were aged between 31 years and 50 years (n=1222=69.6%). Figure 2 (p.63) shows frequencies and percentages of midwives age groups. A comparison between midwives who had been employed as a midwife during the past 5 years (EP5) , and those who had not (NEP5), showed that midwives who had remained registered to practise, but who had not done so for the last 5 years, were older on average than the employed midwives.

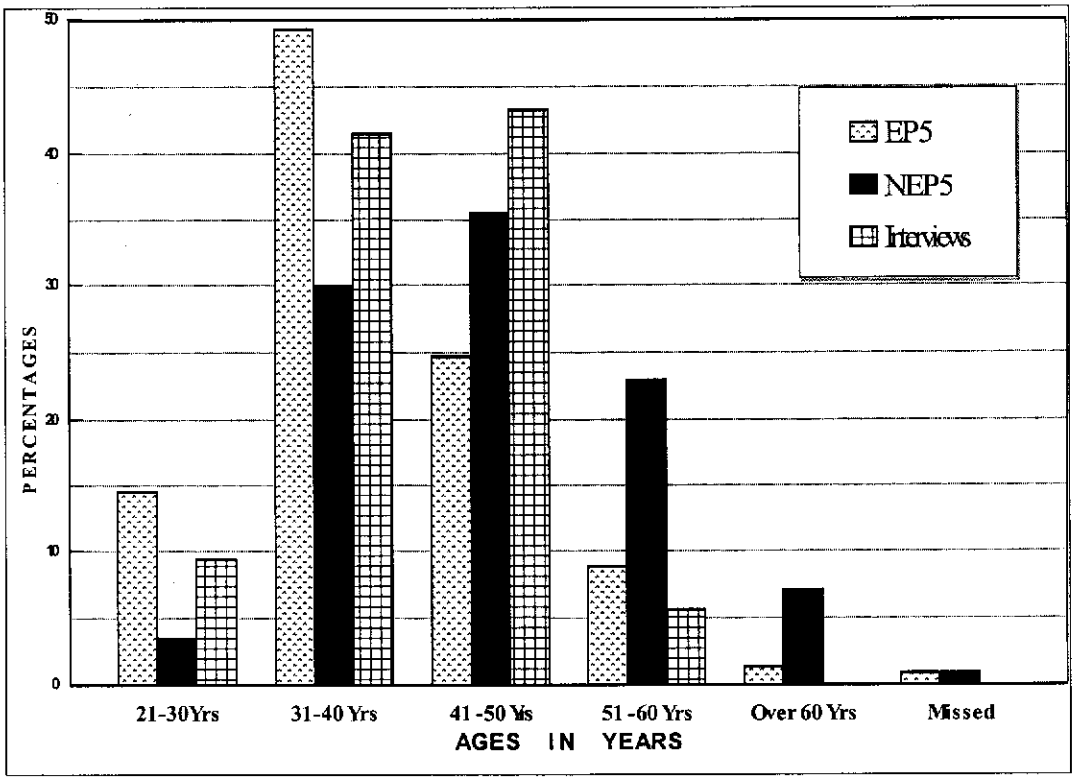


Figure 2: Ages Of Midwives Currently Practising, Not Practising, And Midwives Selected For Interviews.

Of those midwives who were not employed in midwifery for the past 5 years (n=864), 199 (23.1%) were aged between 51 years and 60 years. The same age group for employed midwives (n=882) was 78 (8.8%). In comparison there were more midwives under 30 years of age amongst the employed midwives (n=126=15.5%, than the unemployed (n=29=3.5%). (Figure 2 also shows the differences between age groups of the survey respondents employed, or not employed, as midwives in the past 5 years, and the ages of midwives who participated in the in-depth interviews (Interview Group) but were not included in the questionnaire response frequencies).

4.2.2 Sex

Of the 1754 completed survey questionnaires 19 (1.1%) of the respondents were male.

4.2.3 Postcodes of survey participants

With New South Wales, Victoria and Western Australia being the three participating states, questionnaires returned were from midwives on the registers of one or more of

these states. There were 41 (2.4%) responses from postcodes outside of the 3 sample states.

4.2.4 Country of birth

Australia was the country of birth for 1414 (80.6%) of the respondents (n=1754). A further 188 (10.5%) were born in the UK or Ireland; 61 (3.5%) were born in Asia; 25 (1.4%) in Europe; 22 (1.3%) in New Zealand, and 44 (2.3%) indicated "other" than the above countries.

English was given as the first language of 1698 (96.8%) of the respondents; 50 (2.9%) indicated "other", and there were 6 (.3%) missed responses.

4.2.5 Country of initial qualification

Australia was the country for initial qualification as a midwife for 1520 (86.7%). There were 211 (12%) with initial qualification gained in UK or Ireland, while New Zealand, Asia and "other" accounted for 1% (18). The results indicate that most of the participating midwives received their midwifery education within Australia or the UK. There were 5 (.3%) missed responses.

4.2.6 Registration and years of practice

The majority of midwives had been registered to practise for 10 years or more i.e. 1488 (75%). The range of years registered spanned from less than 3 years (135=7.7%) to more than 37 years (51 = 2.9%). Figure 3 (p.65) provides a percentage comparison of the years practised by currently practising midwives (EP5 group), midwives who had not practised in the last five years (NEP5 group), and midwives who participated in the in-depth interviews (interviews group).

The majority of midwives had practised less than 10 years i.e. 1212 (69.1%); 435 (24.8%) had practised less than 1 year and of these 235 (13.4%) had never practised after registering. A total of 438 (25%) midwives had practised for over 10 years. There were 126 (7.2%) respondents who had taken a course to re-register as a midwife.

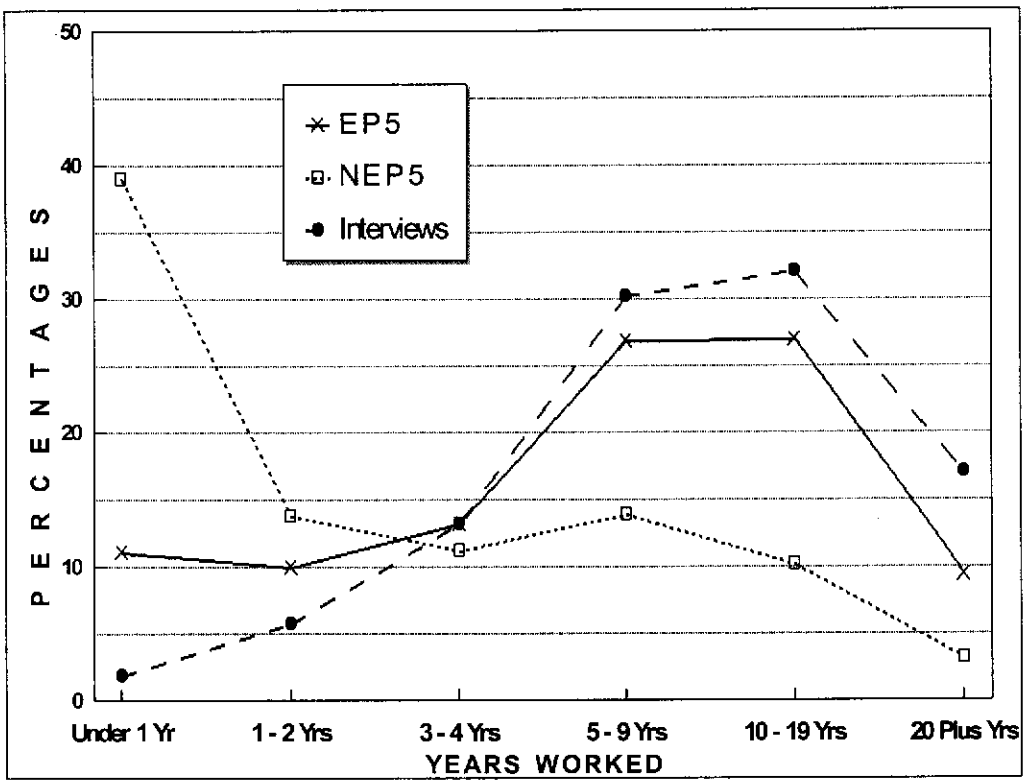


Figure 3: Comparison Of Years Of Practice Of (EP5) Currently Practising Midwives; (NEP5) Midwives Who Have Not Practised In The Past Five Years; And (Interviews) Midwives Selected For Interviews.

4.2.7 Employment status

Of the 1754 questionnaire respondents, 882 (50.3%) had been employed as a midwife during the past five years (as at December, 1993). A total of 864 (49.3%) had not been employed as a midwife during this period of time.

Reasons given for non employment as a midwife are shown on Table 3 (p.66). Of the 864 midwives' responses stating reasons for non employment as a midwife during the past 5 years, 408 (47.2%) stated they preferred other nursing options; 203 (23.5%) indicated family and personal commitments; 121 (14%) said they lacked confidence to practise midwifery; 96 (11.1%) stated that there were no available midwifery positions, 39 (4.5%) said they had not found career opportunities; 38 (4.4%) said they disliked midwifery, and 42 were retired. In response to the question of whether or not they had been employed in any other capacity during the past five years where their midwifery knowledge and skills were utilised there were 1225 affirmative responses. Of these 646 referred to nursing positions and 479 to non nursing occupations.

Table 3 Reasons why not Employed as a Midwife During the Past Five Years.

n=864

	f	%
No position available	96	11.1 %
Family commitments	203	23.5 %
Lack of career opportunity	39	4.5 %
Disliked midwifery	38	4.4 %
Preferred other nursing options	408	47.2 %
Lacked confidence	121	14.0 %
Retired	42	4.9 %
Other reasons	152	17.6%

(% = percentage of total responses given)

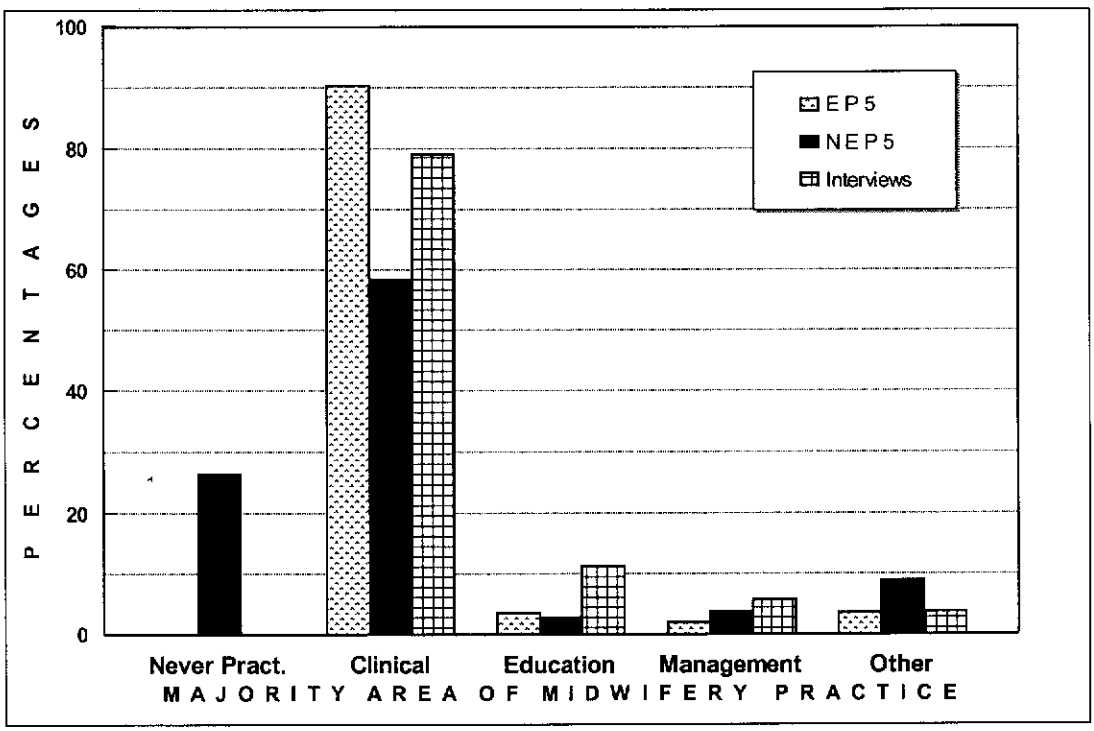


Figure 4: Majority Area Of Midwifery Practice

4.2.8 Educational status

Midwives indicated a wide range of courses that they had completed. Of the 1754 midwives completing the survey questionnaire 4 had completed a Doctor of Philosophy degree; 30 had completed a Masters degree; 124 had completed a post graduate diploma, and 285 had completed Bachelor degrees. Additional nursing qualifications included: general nursing 1734; child health 213; neonatal intensive care 70; other clinical specialties 418.

Non nursing qualifications included: management 73; education 58, and other non clinical qualifications 132. Figures 5 and 6 (p.72) provide comparative percentages for tertiary qualifications, nursing and other qualifications, between midwives currently practising (EP5 group); midwives who had not practised for the past five years (NEP5 group), and midwives selected for interviews (Interviews group).

4.2.9 Area of majority of experience

In response to the question of what category would best describe the majority of each midwife's experience, clinical practice (including patient education) was nominated by 1304 (74.3%); never practised, 235 (13.4%); integrated experience 76 (4.3%); education 55 (3.1%); management 51 (2.9%); missed response 33 (1.9%). Figure 4 (p.66) shows the percentage comparison between the randomly selected survey sample respondents and the purposively selected interviewees.

4.2.10 Membership with professional nursing colleges and associations

Four organisations were nominated in the questionnaire. Responses on membership status showed 780 (44.5%) with the Australian Nursing Federation; 238 (13.6%) with the Australian College of Midwives; 141 (8%) with the New South Wales College of Nursing, and 104 (5.9%) with the Royal College of Nursing Australia. Table 4 (p.68) gives a further breakdown of the percentages of membership status.

Table 4 a Members of Professional Nursing Colleges and Australian Nursing Federation

A.C.M.I.	Australian College of Midwives Inc.
R.C.N.A.	Royal College of Nursing
N.S.W.C.O.N.	New South Wales College of Nursing
A.N.F.	Australian Nursing Federation

Percentages of Membership of the Survey Respondents (n=1754)

Members belonging to A.C.M.I.	13.6%
Members belonging to R.C.N.A.	5.9%
Members belonging to N.S.W.C.O.N.	8.0%
Members belonging to A.N.F.	44.5%

Table 4 b Percentages of Membership of the Individual Groups

	A.C.M.I.	R.C.N.A.	N.S.W.C.O.N	A.N.F.
EP5 (n=882)	24.8%	4.6%	5.3%	54.1%
NEP5 (n=864)	2.2%	7.2%	10.9%	34.7%
Interviews (n=53)	71.7%	9.4%	18.9%	71.7%

These findings demonstrate a much higher membership in the four nominated professional organisations by those midwives purposively selected for the interviews. There is also a greater membership in the nursing colleges, by those not employed as midwives in the past 5 years (NEP5), than with the Australian College of Midwives Inc..

4.2.11 Maternity services consumer status

Half (50.1% = 878) of the survey sample respondents said they had not been a consumer of obstetric services during the past 12 months i.e. (from the time the questionnaire was received during May - December 1993). An additional 185 indicated the question was not applicable. There were 215 (12.3%) midwives who indicated they had been a

childbearing woman during these months, and a further 476 (27.1%) said they had been involved as consumers through close family or friends (Table 5 p.69). The satisfaction ratings given by these consumer midwives for aspects of midwifery care is demonstrated in Table 6 (p.69).

Table 5 Consumer of Maternity Services Within Australia Within the Past 12 Months. **n = 1754**

Midwives as :-	f	%
a childbearing woman	215	12.3%
an involved family member / friend	476	27.1%

Table 6 Consumer Midwives' Satisfaction with Aspects of Midwives' Care.

	Satisfied		Needs Improving		No Comment	
ASPECT	f	%	f	%	f	%
Information given by midwives	344	49.8	271	39.2	76	11.0
Support given by midwives	424	61.4	199	28.8	68	9.9
Care given by midwives	450	65.1	180	26.0	61	8.8
Competence of midwives	456	66.0	161	23.3	74	10.7
Interpersonal skills of midwives	353	51.1	268	38.8	70	10.1
Availability of midwives	322	46.6	288	41.7	81	11.8

n=691

4.3 Interviewees and fieldwork

A total of 75 interviewees participated in the study. The initial 45 interview settings were selected using purposive sampling, as described in the methodology section (p.51). The branch executives of the ACMI for New South Wales, Victoria and Western Australia followed the proposal of the researcher in choosing midwives across a stratified sample of practice settings within each state. Within each setting midwives were recommended as interviewees based on their practice role i.e. midwives in clinical practice, education and management. In some settings midwives interviewed had roles that integrated clinical, management and education. A list of maternity care settings visited for the purposes of interviewing and non- participative observation is provided as Appendix 4.

Of the 75 midwives interviewed 53 completed the survey questionnaire some time after the interview and returned it by mail. These midwives voluntarily included their names to allow the researcher the opportunity to compare their questionnaire responses to the information gained through the interviews and through non participant observation by the researcher in the diverse practice settings. Data from these questionnaires has been held separate to the randomly selected survey sample. It has provided comparative data from a group of purposely and theoretically selected midwives, considered by their professional colleagues to be well informed in their areas of practice. Throughout the presentation of the findings comparisons have been made between this group of midwives and the randomly selected survey sample midwives.

4.3.1 Age and sex of interviewees

Of the 53 midwives who completed the questionnaire in addition to participating in interviews, the majority were aged between 31 years and 50 years (85%). One of the midwives interviewed was a male.

4.3.2 Country of birth and initial qualification

Australia was the place of birth for 43 of the respondents, with 8 born in the UK or Ireland, 1 born in New Zealand and 1 stated as "other". These midwives had all gained their initial qualification in Australia (45) or the United Kingdom (8).

4.3.3 Years qualified and years practised

There was a wide range in the responses to both these questions. The majority of respondents had been registered to practise (43 = 81%) from over 3 years up to 23 years. Six indicated that they had completed a re-registration course at some time. Two midwives had been registered for over 31 years. There was a similar wide range in the number of years practised.

4.3.4 Educational status

Of the 53 interviewees responding to the questionnaire 2 had completed Masters degrees; 7 had completed post graduate diplomas; and 15 had completed Bachelor degrees.

Additional nursing qualifications included; 53 general nursing; 5 child health nursing; 3 neonatal intensive care; and 24 had completed certified courses in clinical specialties. Other qualifications included; 6 with management qualifications and 4 with education certificates.

Figures 5 and 6 (p.72) compare the educational status of this group of respondents with the randomly selected sample respondents.

4.3.5 Area of majority of midwifery practice

Midwives participating in interviews who also completed the survey questionnaire i.e. 53 of 75, indicated their majority areas of practice as ; 42 (79.2%) clinical (including patient teaching); 6 (11.3%) education; 3 (5.7%) management, and 2 (3.8%) as integrated.

4.3.6 Membership with professional nursing colleges and associations

Membership with the Australian College of Midwives was greater among the interviewees than the randomly selected survey sample midwives (Table 4b p.68) with 38 (71.1%) indicating membership. Identical figures were given for membership with the Australian Nursing Federation by this group.

There were 10 (18.9%) midwives who indicated membership with the New South Wales College of Nursing, and 5 (9.4%) with the Royal College of Nursing Australia.

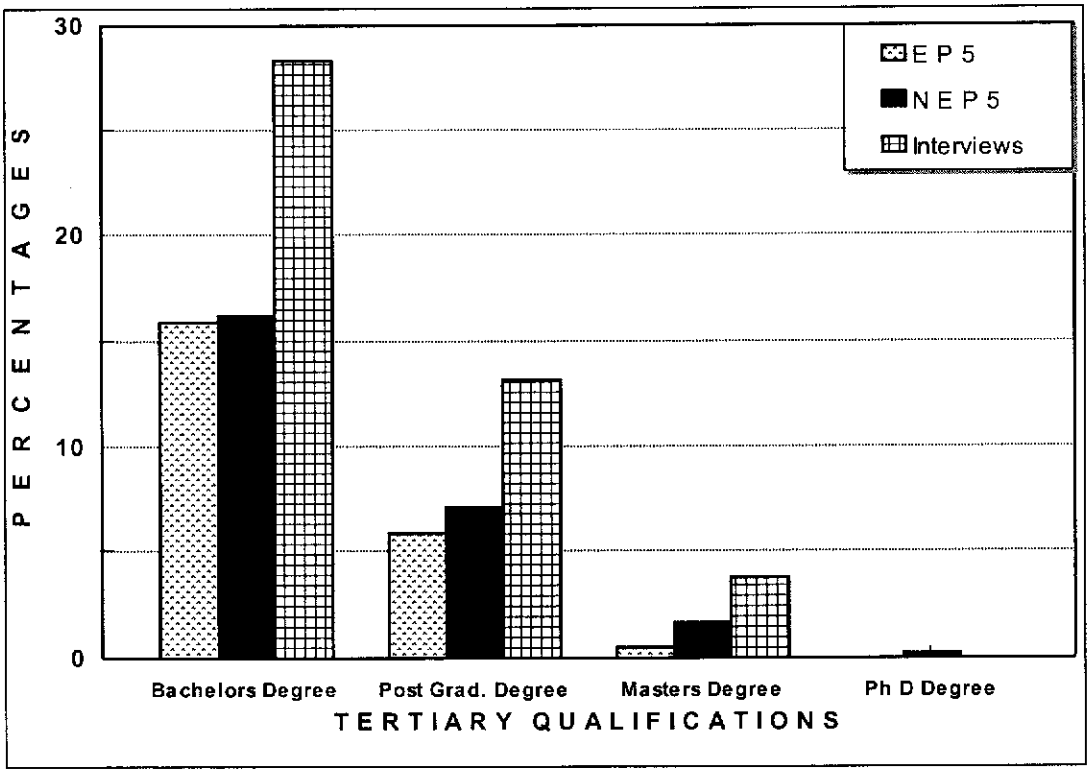


Figure 5: Tertiary Qualifications Of Practising Midwives (EP5); Midwives Who Had Not Practised In The Past Five Years (NEP5); And Midwives Selected For Interviews (Interviews).

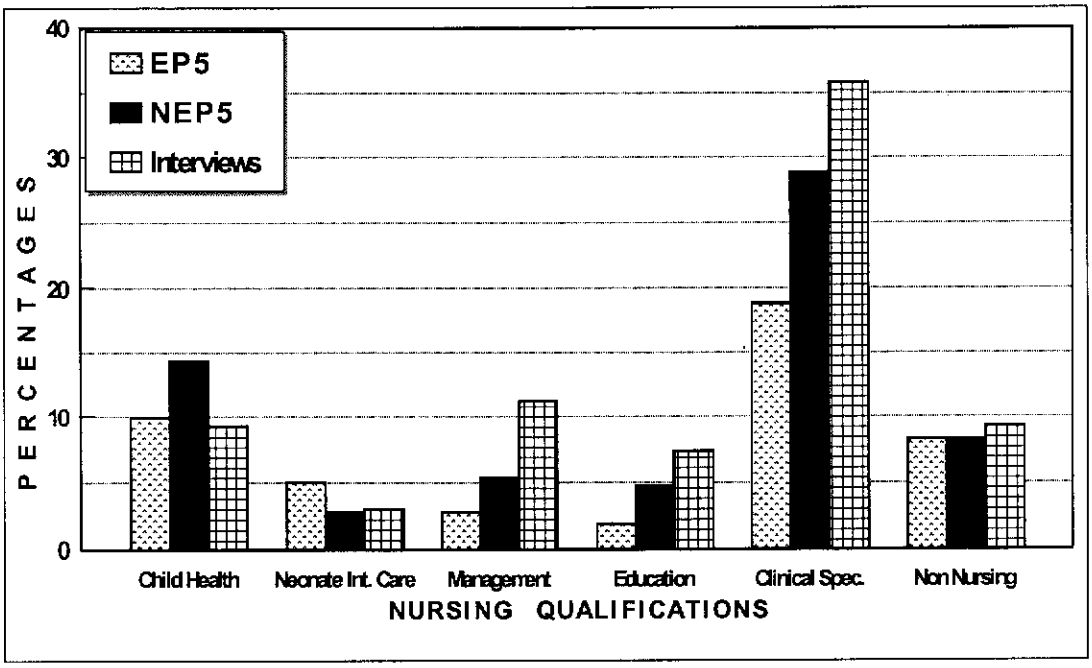


Figure 6: Nursing And Other Qualifications

4.3.7 Maternity services consumer status

Of the interviewee respondents to the questionnaire 27 (50.9%) had not been consumers of obstetric services during the past 12 months (from the time the questionnaire was received during May - December 1993). There were 22 who had been involved through close family or friends, and 3 had been childbearing woman during that time.

4.4 Australian midwives practice settings

Practice settings visited by the researcher during fieldwork non-participative observation and interviewing are listed in Appendix 4 . The methodology for conducting the in-depth interviews outlines the procedure used in choosing the settings to be visited and the midwives to be interviewed initially in each of the three participating states. The intent of the researcher was to visit a variety of locations nominated by the midwives as their practice settings. This included public and private teaching and non-teaching hospitals and outpatient clinics, regional and district hospitals, small country hospitals and remote areas. Birth centres, community health centres and private midwives' practices were also visited.

Throughout this study practice settings are discussed in conjunction with the models of service provision defined by the Joint Birth Consultative Committee (1992). These models of care are: midwifery care; general practitioner obstetric care; specialist obstetric care; and shared care. The relationship between midwives' practice settings and models of care is demonstrated in this extract from the Joint Birth Consultative Committee report:

> *Midwives are ideally placed to function as primary health care professionals. Their sphere of practice has been clearly articulated and agreed at international levels by midwives, their obstetrical colleagues and the World Health Organisation.*
>
> *That practice may occur in hospital based maternity services, birthing centres, designated hospital beds for midwives, and community based or visiting midwife services.*

> *An abundance of midwifery expertise is located geographically close to families, thus providing family centred care in many roles associated with birthing* (JBCC, 1992: 4).

The impact these models of care can have on the midwives' sphere of practice within specific practice settings will be demonstrated throughout the findings of this study.

In addition to levels of service provision and models of care *Organisational Structures* within practice settings determined the midwives' sphere of practice within each setting. Throughout this study these structures have been referred to using terminology agreed upon through consultation with the advisory panel of midwives during the preparation of the questionnaire, and evaluated during the pilot study. Interviews with midwives within these defined practice settings have confirmed the uniformity of usage of these definitions of practice settings amongst Australian midwives.

The terminology used throughout the survey questionnaire and interviews with midwives to define practice settings within levels 1, 2 and 3 of maternity service provision was: *Specialist Obstetrician Hospital Care; General Practitioner Hospital Care; Birth Centres; Alternative Birthing Suites (attached to a labour ward); Domiciliary setting (home or community) and Other.*

Demographic data relating to broad practice settings is presented in this section of the study. More detailed descriptive data is given throughout the study findings when the relationships between practice settings and practice opportunities are discussed.

4.4.1 Level of service provided by employing organisations

(as defined in Appendix 8)

Responses to the survey questionnaire, from those midwives who had been employed as a midwife during the past 5 years, indicated 277 (31.4%) had been employed in organisations providing level 1 services; 409 (46.4%) had been employed in level 2 organisations, and 247 (28.0%) had practised in organisations providing level 3 services. There were midwives who had worked in organisations providing different levels of care during the past five years.

As illustrated in Table 7 (p.75) midwives interviewed through purposive and theoretical sampling who also replied to the survey questionnaire (n = 53) indicated that

18 (34%) had been employed in level 1 organisations; 25 (47.2%) in level 2, and 18 (34%) in level 3 (changes in employment settings account for the above 100% responses).

As these findings are discussed and compared with more specific data relating to midwives' practices, the effect of these levels of service on midwives' practice opportunities is demonstrated.

Table 7 Levels of Service Provision

(Number of midwives who had practised in the past 5 years in organisations providing services at the 3 levels defined by the College of Paediatricians)

	LEVEL 1		LEVEL 2		LEVEL 3		N / A	
	f	%	f	%	f	%	f	%
EP5 n = 882	277	31.4	409	46.4	247	28.0	48	5.40
INTERVIEWS n = 53	18	34.0	25	47.2	18	34.0	2	3.80

Totals exceed 100 % as respondents may have worked at more than one level during the past five years.

4.4.2 Employment mobility

The majority of midwives employed during the past 5 years (n=882) had practised within the three states chosen for the study. New South Wales was nominated by 293 (16.7%); Victoria 396 (22.6%), and Western Australia 174 (9.9%).

Midwives with postcodes from these three states also indicated that they had worked in other Australian states and overseas during the past 5 years. Other employment states and countries included: Capital Territory 13; Northern Territory 24; Queensland 34; South Australia 16; Tasmania 11; UK or Ireland 62; Asia 11; America 4; New Zealand 3, and "other" 11.

Of the 53 interviewees responding to the questionnaire, 24 had practised in New South Wales; 19 in Victoria; 13 in Western Australia, and 4 in other Australian states. UK or Ireland was nominated by 9 (17%) of these purposively selected midwives, with 4 having worked in other countries.

4.5 The actual role of the Australian midwife

This section presents data findings from the survey questionnaire of a randomly selected sample (n=1754) of midwives registered to practise within one of the three selected states considered to reflect the diverse practice settings found throughout Australia. The question of the actual role of the midwife in providing obstetric and neonatal care was analysed according to antenatal, intrapartum and postnatal areas of practice.

4.5.1 Antenatal practice

This section of the findings describes what midwives actually do in the provision of antenatal care. Throughout this study antenatal care refers to care given throughout the prenatal period, which may include preconceptual care, and which extends through to the commencement of labour. The midwives involvement in providing the technical and scientific aspects of antenatal care, and their perceptions of their levels of knowledge and skills required to meet the physical, emotional and practical needs of women and their families during this period, are described.

The findings presented in this section on antenatal practice provide the factual information required to identify and discuss issues affecting midwives' ability to provide antenatal care that meets the ACMI *Standards for the Practice of Midwifery (1989).*

4.5.1.1 Antenatal practice settings

Of the 1754 randomly selected survey sample respondents, 606 had been involved in providing antenatal care during the past five years. There were 192 (31.7%) who had practised in health service organisations providing level 1 services (see Appendix 8 for definitions of service levels); 307 (50.7%) had been employed in level 2 hospitals and 178 (29.4%) in level 3 hospitals. (The 111.8% total percentage indicates that some midwives worked in organisations providing different levels of service during the 5 year period).

Tables 8, 9 and 10 (pp.77-78) provide more detail on these practice settings within the three levels of service. It should be noted that each level may also provide a lower level of service e.g. a level 3 hospital provides care to women having normal pregnancies as well as providing intensive care during complicated pregnancies.

The findings illustrated in Table 11 (p.79) indicate hospital inpatient care as the setting for the majority of the 606 midwives providing antenatal care. A total 508

(83.8%) had worked in settings where they had provided hospital antenatal inpatient care. There were 278 (45.9%) who had provided hospital clinic outpatient care.

Table 8 Antenatal Settings Level 1 n = 192

	Public	Private	Both	Neither
Hospital in patient care	115 (59.9%)	17 (8.9%)	22 (11.5%)	38 (19.8%)
Hospital clinic out patients	75 (39.1%)	3 (1.6%)	2 (1.0%)	112 (58.3%)
Health centre	7 (3.6%)	1 (0.5%)	1 (0.5%)	183 (95.3%)
Family planning	6 (3.1%)	1 (0.5%)	1 (0.5%)	184 (95.8%)
Medical practice, surgery	5 (2.6%)	4 (2.1%)	1 (0.5%)	182 (94.8%)
Domiciliary setting	30 (15.6%)	3 (1.6%)	2 (1.0%)	157 (81.8%)
Birth centre & Other	20 (10.4%)	2 (1.0%)	2 (1.0%)	168 (87.5%)

Table 9 Antenatal Settings Level 2 n = 307

	Public	Private	Both	Neither
Hospital in patient care	164 (53.4%)	51 (16.6%)	58 (18.9%)	34 (11.1%)
Hospital clinic out patients	131 (42.7%)	14 (4.6%)	7 (2.3%)	155 (50.5%)
Health centre	14 (4.6%)	1 (0.3%)	2 (0.7%)	290 (94.5%)
Family planning	13 (4.2%)	1 (0.3%)	1 (0.3%)	292 (95.1%)
Medical practice, surgery	5 (1.6%)	6 (2.0%)	2 (0.7%)	294 (95.8%)
Domiciliary setting	24 (7.8%)	3 (1.0%)	5 (1.6%)	275 (89.6%)
Birth centre & Other	21 (6.8%)	8 (2.6%)	2 (0.7%)	276 (89.9%)

Table 10 Antenatal Settings Level 3 n = 178

	Public	Private	Both	Neither
Hospital in patient care	112 (62.9%)	9 (5.1%)	40 (22.5%)	17 (9.6%)
Hospital clinic out patients	86 (48.3%)	5 (2.8%)	8 (4.5%)	79 (44.4%)
Health centre	8 (4.5%)	1 (0.6%)	3 (1.7%)	166 (93.3%)
Family planning	7 (3.9%)	1 (0.6%)	1 (0.6%)	169 (94.9%)
Medical practice, surgery	3 (1.7%)	3 (1.7%)	1 (0.6%)	171 (96.1%)
Domiciliary setting	23 (12.9%)	0 (0.0%)	2 (1.1%)	153 (86.0%)
Birth centre & Other	20 (11.2%)	0 (0.0%)	1 (0.6%)	157 (88.2%)

Table 11 Antenatal Practice Settings n = 606

	PUBLIC		PRIVATE		B O T H		TOTAL
Hospital inpatient care	341	56.3%	74	12.2%	93	15.3%	83.8%
Hospital clinic outpatient care	240	39.6%	22	3.6%	16	2.6%	45.9%
Women's health centre (or clinic)	30	5.0%	5	0.8%	6	1.0%	6.8%
Family planning centre (or clinic)	27	4.5%	3	0.5%	2	0.3%	5.3%
Medical practitioners surgery	12	2.0%	12	2.0%	4	0.7%	4.6%
Domiciliary setting	64	10.6%	8	1.3%	6	1.0%	12.9%
Birth centre & Other	59	9.7%	10	1.7%	4	.7%	12.0%
Content analysis of 'other' (where stated)							
Antenatal education parenting class	5		3				
Community health centre	10		0				
Midwives antenatal clinic (specialised eg. adolescent)	3		0				
Birth centre	4		0				
Private midwives practice	0		3				
Emergency service	3		0				

Other settings were more notable for their lack of provision of antenatal midwifery care. Midwives stating they had not provided care within these settings were as follows: women's health centres 565 (93.2%); family planning centres 574 (94.7%); medical practitioner's surgery 578 (95.4%); domiciliary setting 528 (87.1%), birth centre and other 533 (88%).

4.5.1.2 Practice area

Midwives participating in the questionnaire survey, who had practised antenatal care during the past 5 years, were asked to nominate the areas of midwifery practice in which they had been involved. Responses indicated that the majority (489 = 80.7%) had been involved in the clinical care and individual client teaching aspects of antenatal care; 314 (51.8%) had been involved in antenatal and parenthood education for client groups; 137 (22.6%) were midwifery educators; 122 (20.1%) had managed antenatal services, and 49 (8.1%) had been involved in antenatal research.

4.5.1.3 Involvement of families of childbearing women

In response to the question of whether their antenatal care involved the families of the childbearing women there were 391 (64.5%) who answered '*yes*'. Of the remaining 215 who had provided antenatal care, 197 (32.5%) indicated that care had not included the family. A further 18 did not respond to the question.

4.5.1.4 Level of practice autonomy

Midwives were asked to consider a list of tasks performed in the provision of antenatal care. A legend was provided giving six levels of performance (Appendix 2). Midwives were asked to indicate only the level at which they most usually performed specific tasks. The response frequencies and percentages are set out in Table 12 (pp.81-83).

The findings illustrated in this table indicate that the antenatal tasks most frequently nominated by midwives as having been performed during the past 5 years were: urinalysis 92.2%; fetal heart monitoring with pinards stethoscope or doppler 92.1%; vital signs assessment 90.3%; obtaining and documenting an obstetrical history 89.6%; and abdominal assessment, palpation and auscultation 80.3%. Tasks most frequently described as not having been performed during the past 5 years were: ultrasound 77.3%; pre conceptual care counselling 72.6%; writing and discussing a family centred care plan 53.8%; discussing a family centred care plan with the client 44.1%; ordering laboratory tests 36.8%, and taking vaginal or cervical swabs 34.9%.

The total number of responses indicating the *perceived level of autonomous practice* in the performance of specific antenatal care procedures (f), showed the level of autonomy most usually nominated by midwives as *following policies and procedures* (f=4953=39.54%). *Procedures not performed for the past 5 years* were ranked next (f=3741=29.86%); then in order, *autonomous decision making* (f=1925=15.36%); *following direct medical orders* (f=1181=9.4%); *performing a procedure with a medical practitioner present in a supervisory capacity* (f=204=1.6%), and *assisting a medical practitioner to perform a procedure* (f=523=4.2%).

Table 12 Most Usual Level of Antenatal Task Performance (n=606 of EP5)

MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
pre conceptual care counselling	31	5.1	3	0.5	22	3.6	64	10.6	46	7.6	440	72.6
antenatal care counselling	21	3.5	8	1.3	59	9.7	302	49.8	100	16.5	116	19.1
obtain & document medical/ surgical history	10	1.7	3	0.5	51	8.4	381	62.9	84	13.9	77	12.7
obtain & document an obstetrical history	11	1.8	5	0.8	42	6.9	392	64.7	93	15.3	63	10.4
obtain & document a psycho/ social history	8	1.3	5	0.8	36	5.9	360	59.4	87	14.4	110	18.1
conduct an initial maternal physical assessment	55	9.1	15	2.5	38	6.3	250	41.3	69	11.4	179	29.5
subsequent abdominal assessment palpation and auscultation	10	1.7	13	2.1	49	8.1	333	55.0	136	22.4	65	10.7
subsequent vital signs assessment	5	0.8	10	1.7	44	7.3	334	55.1	154	25.4	59	9.7
ultrasound	102	16.8	6	1.0	11	1.8	14	2.3	4	0.7	469	77.3
cardiotocograph (procedure)	9	1.5	2	0.3	78	12.9	276	45.5	99	16.3	142	23.5
C T G (interpretation)	26	4.3	19	3.1	104	17.2	244	40.3	86	14.2	127	20.9
fetal heart monitoring with pinards stethoscope or Doppler	7	1.2	2	0.3	36	5.9	302	49.8	211	34.8	48	7.9
ordering laboratory tests	48	7.9	17	2.8	173	28.5	124	20.5	21	3.5	223	36.8
venipuncture	36	5.9	6	1.0	124	20.5	204	33.7	51	8.5	185	30.0
taking vaginal/cervical swabs	57	9.4	13	2.1	161	26.6	131	21.6	33	5.4	211	34.9
urinalysis	5	0.8	0	0.0	36	5.9	311	51.3	207	34.2	47	7.8
family care plan discussed with client	7	1.2	4	0.7	16	2.6	191	31.5	121	20.0	267	44.1
family care plan written	5	0.8	3	0.5	14	2.3	167	27.6	86	14.2	331	54.6
family care plan discussed and written	5	0.8	3	0.5	17	2.8	168	27.7	87	14.4	326	53.8

MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP f %	SP MP Present f %	SP on MP Direct Orders f %	SP Following P&P f %	Autonomy in Making Decisions f %	Not Done in past five years f %
identification of factors requiring referral to other health professionals	25 4.1	12 2.0	70 11.6	239 39.4	128 21.1	132 21.8
care of high risk clients	39 6.4	55 9.1	200 33.0	166 27.4	22 3.6	124 20.5

The only antenatal procedure rated as being most usually performed at the level of assisting the medical practitioner was that of ultrasound. There were 102 (16.8%) midwives who said they usually assisted a medical practitioner for this procedure, while 469 (77.3%) indicated they had not performed the procedure during the past 5 years.

The level of perceived autonomy in the performance of antenatal care procedures was compared between practice settings. Although there was a significant association (Crosstabs procedure $\chi^2 = 14.30$ df 7, $p = .04$) between the levels of care provided and the opportunities to provide care to the high risk patient, there was no significant difference in the midwives' perception of the level of autonomy at which the antenatal care procedures were performed.

Data from the in-depth interviews are presented in Chapter Seven of this study. This adds meaning to the numeric descriptive data from the questionnaire. The numerous variables (defined as categories) that contributed to the inconsistency and fragmentation of practice are demonstrated.

4.5.1.5 Midwives level of input to the development of the policies and procedures guiding the practice of antenatal care

The most usual level of autonomy in the performance of antenatal care procedures was indicated by midwives as *self performed following organisational policies and procedures* (39.54%). In response to the question of what was their highest level of input to the development of these policies 81% said they had indirect, little, or no input; 58 (9.6%) were involved in the direct preparation of policies and procedures, and 53 (8.7%) were involved in the determination of policies and procedures. Table 13 (pp. 83-86) illustrates in more detail the level of input midwives considered themselves to have had in the development of policies and procedures within the antenatal practice settings in which they were employed during the past five years. There was no statistically

significant association between public and private hospital employed midwives' input to the development of policies and procedures in both inpatient and outpatient care (χ^2=10.01879, df8, p=.2637), but midwives working in level 1 care settings were more likely to be involved in direct preparation of policies and procedures controlling their practice than midwives working in level 3 organisations (χ^2 = 13.18, df 6, p=.04).

Table 13 Relationship Between Input to Policies and Procedures and Midwives' Employment Settings.

ANTENATAL

SETTING	No Input		Little Input		Indirect Input		Direct Input		Determine Policies & Procedure	
	f	%	f	%	f	%	f	%	f	%
Public hospital in patient care n=341	77	22.6	82	24.0	116	34.0	35	10.3	31	9.1
Private hospital in patient care n=74	13	17.6	17	23.0	28	37.8	9	12.2	7	9.5
Public and private in patient care n=93	28	30.1	19	20.4	34	36.6	4	4.3	8	8.6

Note - 98 (16.2%) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input		Little Input		Indirect Input		Direct Input		Determine Policies & Procedure	
	f	%	f	%	f	%	f	%	f	%
Public hospital clinic outpatient care n=240	58	24.1	46	19.2	88	36.7	26	10.8	22	9.2
Private hospital clinic outpatient care n=22	2	9.0	6	27.3	7	31.8	4	18.2	3	13.6
Public and private hospital clinic out- patient care n=16	0	0.0	4	25.0	11	68.8	0	0.0	1	6.3

Note - 328 (54.0 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public womens health centre n=30	5	16.6	8	26.7	13	43.3	2	6.7	2	6.7
Private womens health centre n=5	2	40.0	2	40.0	0	0.0	0	0.0	1	20.0
Public & private womens health centres n=6	1	16.7	1	16.7	3	50.0	0	0.0	1	16.7

Note - 565 (93.2 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public family planning centre (or clinic) n=27	5	18.5	7	25.9	10	37.0	1	3.7	4	14.8
Private family planning centre (or clinic) n=3	0	0.0	0	0.0	2	66.7	0	0.0	1	33.3
Public & private family Planning centre (or clinic) n=2	0	0.0	1	50.0	1	50.0	0	0.0	0	0.0

Note - 574 (94.7 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public medical practitioners rooms n=12	3	25.0	0	0.0	6	50.0	2	16.7	1	8.3
Private medical practitioners rooms n=12	2	16.7	4	33.3	3	25.0	0	0.0	3	25.0
Public & private medical practitioners rooms n=4	0	0.0	1	25.0	2	50.0	0	0.0	1	25.0

Note - 578 (95.37 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public domiciliary setting n=64	14	22.4	13	20.3	23	35.9	6	9.4	8	12.5
Private domiciliary setting n=8	0	0.0	0	0.0	3	37.5	2	25.0	3	37.5
Public & private domiciliary setting n=6	1	16.7	1	16.7	1	16.7	1	16.7	2	33.3

Note - 528 (87.13 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

Table 13 Continued

SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public - other n=59	15	25.5	10	16.9	19	32.2	7	11.9	8	13.6
Private - other n=8	4	40.0	2	20.0	2	20.0	0	0.0	2	20.0
Public & private other n=6	0	0.0	1	25.0	1	25.0	1	25.0	1	25.0

Note - 533 (87.95 %) of midwives providing antenatal care had not been employed in these settings during the past 5 years.

4.5.1.6 Liaison with other health professionals

There was a linear relationship evident between the levels of care provided by organisations and liaison occurring most frequently with other health professionals. In level 1 organisations the general practitioner was nominated as being the medical person most frequently contacted (n=149 = 77.6%), while level 2 and level 3 organisations liaised more frequently with specialist obstetricians (L2 =86.3%, L3 = 88.8%). Table 14 below demonstrates the increased liaison with specialist medical personnel in relation to the levels of service provided. The same increase in liaison between midwives and other health professionals providing antenatal services is seen in the findings presented in Table 15 (p.87). Physiotherapists, social workers and dietitians were most frequently nominated as being involved in the provision of antenatal care in liaison with the midwives.

Table 14 Midwives Antenatal Liaison With the Medical Profession by Levels.

	Level 1 f	%	Level 2 f	%	Level 3 f	%
General Practitioner	149	77.6	199	64.8	80	44.9
Specialist Obstetrician	105	54.7	265	86.3	158	88.8
Paediatrician	51	26.6	127	41.4	85	47.8
Anaesthetist	31	16.1	77	25.1	48	27.0
Other Medical Personnel	7	3.6	18	5.9	10	5.6

Table 15 Midwives Liaison With Other Health Professionals by Levels.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Physiotherapist	92	47.9	173	56.4	120	67.4
Social Worker	58	30.2	157	51.1	116	65.2
Dietitian	61	31.8	187	60.9	110	61.8
Pharmacist	53	27.6	119	38.8	84	47.2
Pathologist	53	27.6	120	39.1	74	41.6
Radiologist	36	18.8	99	32.2	48	27.0
Minister of Religion	28	14.6	64	20.8	62	34.8
Psychologist	15	7.8	39	12.7	35	19.7
Occupational Therapist	8	4.2	27	8.8	25	14.0
Other Health Professional	10	5.2	16	5.2	13	7.3

4.5.1.7 Utilisation of midwifery knowledge and skills in providing antenatal care

Although the opportunity was given in the questionnaire for midwives to rate their utilisation of knowledge and skills as two separate items, responses indicated that they did not perceive any significant difference between the utilisation of skills and knowledge. Overall, 26.7% stated their knowledge and skills were poorly utilised; 37.8% said they were utilised most of the time; 27.7% said they were well utilised, and 5.6% felt their knowledge and skills were fully utilised.

The perception of the utilisation of knowledge and skills in the provision of antenatal care was lowest in level 1 organisations and highest in level 3 (Tables 16 and 17 p.88).

Table 16 Utilisation of Midwives Antenatal Knowledge (by Hospital Levels.)

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	1	0.5	5	1.6	4	2.2
Poorly utilised	63	32.8	73	23.8	29	16.3
Utilised most of time	73	38.0	126	41.0	65	36.5
Well utilised	41	21.4	86	28.0	65	36.5
Fully utilised	11	5.7	13	4.2	12	6.7

Table 17 Utilisation of Midwives Antenatal Skills (by Hospital Levels.)

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	1	0.5	4	1.3	7	3.9
Poorly utilised	65	33.9	77	25.1	33	18.5
Utilised most of time	66	34.4	126	41.0	66	37.1
Well utilised	46	24.0	85	27.7	57	32.0
Fully utilised	11	5.7	11	3.6	12	6.7

4.5.1.8 Satisfaction with division of responsibility for antenatal care

Midwives were asked to rate their level of satisfaction with the division of responsibility for antenatal care as it affected their own role within the health care team. The results are illustrated in Table 18 (p.89). They show an overall dissatisfaction rating of 31.5%. This was higher for level 1 and 2 (34.9% & 34.8%) with level 3 being 28.1%.

Table 18 Satisfaction With Division of Responsibility for Antenatal Care.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Dissatisfied	10	5.2	12	3.9	7	3.9
Little satisfaction	57	29.7	95	30.9	43	24.2
Mostly satisfied	74	38.5	150	48.9	83	46.6
Well satisfied	39	20.3	40	13.0	38	21.3
Highly satisfied	8	4.2	6	2.0	4	2.2

4.5.2. Intrapartum practice

This study describes the midwives' practice during the intrapartum period as being the time from the commencement of labour to the completion of the third stage of labour following birth and the expulsion of the placenta. Although the first hour following the completion of the third stage of labour can be referred to as the fourth stage of labour, in this study it is included as postnatal practice. As with the description of antenatal care, the midwives' involvement in providing the technical and scientific aspects of intrapartum care, and their perceptions of their levels of knowledge and skills required to meet the physical, emotional and practical needs of women during this period, is described. This factual information demonstrates what midwives actually contribute towards intrapartum care, while also providing the data base required to identify and discuss midwives' perceptions of their ability to provide intrapartum care that meets the ACMI *Standards for the Practice of Midwifery (1989).*

4.5.2.1 Intrapartum practice settings

Of the 1754 randomly selected survey sample respondents, 660 had been involved in providing intrapartum care during the past five years (Table 19 p.90). Of these, 235 (35.6%) had practised in health care organisations providing level 1 services (see Appendix 8 for definitions of service levels); 341 (51.6%) had been employed in level 2 hospitals and 173 (26.2%) in level 3 hospitals (the 114.4% total indicated that midwives worked in organisations providing different levels of service during the five year period, in fact there were midwives who indicated they were working in more than one intrapartum setting).

Table 19 Intrapartum Practice Settings n = 660

	PUBLIC		PRIVATE		B O T H		TOTAL
Specialist obstetrician hospital care	280	42.4%	106	16.1%	103	15.6%	74.1%
General practitioner hospital care	315	47.7%	73	11.1%	74	11.2%	70.0%
Birth centre	58	8.8%	17	2.6%	9	1.4%	12.7%
Alternative birth suite	69	10.5%	38	5.8%	8	1.2%	17.4%
Domiciliary setting	21	3.2%	10	1.5%	6	0.9%	5.6%
Other	14	2.1%	9	1.4%	3	0.5%	3.9%

Tables 20, 21, & 22 (pp.90-91) provide more detail on the practice settings within the three levels of service. As with all aspects of midwifery care lower levels of service could also be provided within any of the practice settings.

Table 20 Intrapartum Practice Settings Level 1 n = 235 (35.6%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	60	25.5%	29	12.3%	28	11.9%	118	50.2%
General practitioner hospital care	150	63.8%	24	10.2%	31	13.2%	30	12.8%
Birth centre	23	9.8%	2	0.9%	2	0.9%	200	88.5%
Alternative birth suite	22	9.4%	9	3.8%	2	0.9%	200	85.1%
Domiciliary setting	8	3.4%	3	1.3%	3	1.3%	219	93.2%
Other	5	2.1%	2	0.9%	0	0.0%	228	97.1%

It should also be noted that level 2 and level 3 service providing organisations may have provided choices in the models of care. This explains why midwives nominating birth centres, alternative birthing suites, domiciliary and other settings could be employed by organisations providing any level of service.

Table 21 Intrapartum Practice Settings Level 2 n = 341 (51.6%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	164	48.1%	70	20.5%	67	19.6%	40	11.7%
General practitioner hospital care	152	44.6%	47	13.8%	42	12.3%	100	29.3%
Birth centre	25	7.3%	13	3.8%	3	0.9%	300	88.0%
Alternative birth suite	42	12.3%	32	9.4%	5	1.5%	262	76.8%
Domiciliary setting	8	2.3%	6	1.8%	4	1.2%	322	94.4%
Other	6	1.8%	5	1.5%	0	0.0%	329	96.8%

Table 22 Intrapartum Practice Settings Level 3 n = 173 (26.2%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	103	59.5%	14	8.1%	44	25.4%	12	6.9%
General practitioner hospital care	64	37.0%	5	2.9%	16	9.2%	88	50.9%
Birth centre	27	15.6%	2	1.2%	7	4.0%	137	79.2%
Alternative birth suite	26	15.0%	6	3.5%	3	1.7%	138	79.8%
Domiciliary setting	7	4.0%	1	0.6%	1	0.6%	164	94.8%
Other	4	2.3%	1	0.6%	3	1.7%	165	95.4%

In response to the question asking midwives to indicate their intrapartum practice settings (n=660), 489 (74.1%) said they had provided intrapartum inpatient care at a *specialist obstetrician* hospital; 462(70%) at a *general practitioner* hospital; 84 (12.7%) at a birth centre; 115 (17.4%) at an alternative birthing suite attached to a labour ward; 37(5.6%) had provided intrapartum care in a domiciliary setting, and 26 (4%) indicated they had provided intrapartum care at other settings. The percentages given for specialist and general practitioner services are not mutually exclusive as hospitals could provide both models of care. Table 19 (p.90) gives the division of these settings in private and public categories. It can be seen from these tables that the percentage of midwives providing intrapartum care in specialist obstetrician settings increased as the level of service provided increased. Midwives in general practitioner care settings however, decreased as the level of service increased.

4.5.2.2 Practice area

Midwives participating in the survey questionnaire who had been employed during the past five years (n=882), and who had been involved in intrapartum services (n=660), were asked to nominate the areas of care in which they had practised. The majority 617 (93.5%) had provided clinical care; 376 (57%) had been involved in intrapartum education for the clients; 153 (23.2%) were involved in education for midwives; 184 (27.9%) had been managers of intrapartum services, and 41 (6.2%) had participated in intrapartum care research.

4.5.2.3 Involvement of families of childbearing women

Of the 660 midwives who had provided intrapartum care during the past 5 years 566 (85.8%) indicated this had included the families of the childbearing women. There were 79 (12%) who said they had not been involved with the families and there were 15 (2.3%) missed responses.

4.5.2.4 Level of autonomy of practice

Midwives were asked to consider a list of tasks performed in the provision of intrapartum care. A legend was provided giving six levels of performance (Appendix 2). Midwives were asked to indicate only the level at which they most usually performed specific tasks. The response frequencies and percentages are set out in Table 23 (pp.93-100).

These findings indicate a wide range in the frequencies of the perceived most usual level of autonomy at which tasks were performed. For ease of understanding the findings are summarised here within the 3 stages of labour.

4.5.2.4.1 First stage of labour.

During the first stage of labour there were a number of procedures that could be identified as being performed in the capacity of *assisting a medical practitioner* or being *performed under the direct supervision of a medical practitioner*, more frequently than other tasks. These were: electronic fetal heart monitoring using fetal scalp electrodes (27.6%); obtaining and testing fetal scalp sample for pH levels (23.2%); assessment of cervix for induction (40.8%); artificial rupture of membranes (37.5%); insertion of

intravenous cannula (43.1%); and administration of anaesthetic/analgesic drugs via the epidural route (40%). Table 23 below, compares the most usual level of input midwives had to these particular procedures.

Other tasks identified as being less frequently performed by midwives during the first stage of labour were not related to increased medical input. These were: obtaining a family focused psychosocial assessment (21.2% said they had not done so in the past 5 years); reading and interpreting a cardiotocograph (18.8% not in the past five years); development of client/family orientated birth care plan (18.3% not done), and 31.4% had not given hot baths or used other non-drug methods of pain relief (52.1% stated they had not used other methods of pain relief, however, 95.1% had indicated that they provided comfort measures).

Table 23 Most Usual Level of Intrapartum Task Performance

MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
1st Stage Labour												
obtain client history	10	1.5	2	0.3	43	6.5	479	47.6	92	13.9	34	5.2
obtain family focused psychosocial assessment	4	0.6	2	0.3	38	5.8	360	54.5	116	17.6	140	21.2
physical assessment	15	2.3	6	0.9	66	10.0	426	64.5	105	15.9	42	6.3
Continuing Assessment of Labouring Status												
abdominal palpation to assess presentation and descent	7	1.1	2	0.3	47	7.1	400	60.6	172	26.1	32	4.9
monitoring frequency duration and severity of contractions	2	0.3	2	0.3	48	7.3	412	62.4	165	25.0	31	4.8
pain assessment	4	0.6	2	0.3	62	9.4	341	51.7	219	33.2	32	4.9
assessment of vaginal discharge	5	0.8	3	0.5	44	6.7	371	56.2	205	31.1	32	4.9

Table 23 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
assessment of cervix by vaginal examination	53	8.0	16	2.4	134	20.3	274	41.5	121	18.3	62	9.4
assessment of membranes	30	4.5	12	1.8	88	13.3	324	49.1	152	23.0	54	8.2
assessment of fetal position	17	2.6	10	1.5	62	9.4	349	52.9	183	27.7	39	5.9
station of fetus in relation to ischial spines	45	6.8	11	1.7	92	13.9	294	44.5	150	22.7	68	10.3
emotional status of client	3	0.5	2	0.3	37	5.6	301	45.6	286	43.3	31	4.8
maternal vital signs	3	0.5	3	0.5	37	5.6	397	60.2	188	28.5	32	4.9
Continuing Assessment of Foetal Well Being												
observation and assessment of fetal activity	5	0.8	3	0.5	45	6.8	402	60.9	173	26.2	32	4.9
identification of meconium in liquor	4	0.6	5	0.8	41	6.2	361	54.7	212	32.1	37	5.7
fetal heart monitoring with pinards stethoscope or Doppler	2	0.3	3	0.5	36	5.5	387	58.6	198	30.0	34	5.2
electronic fetal heart monitoring (external)	3	0.5	5	0.8	76	11.5	342	51.8	144	21.8	90	13.7
electronic fetal heart monitoring (fetal scalp electrodes)	167	25.3	15	2.3	71	10.8	143	21.7	46	0.7	218	33.1
reading and interpretation of cardiotocograph	41	6.2	29	4.4	102	15.5	252	38.2	112	17.0	124	18.0
obtaining and testing fetal scalp sample for pH testing	149	22.6	4	0.6	10	1.5	20	3.0	2	0.3	475	71.9
Provision of Care 1st Stage												
provision of information about physiologic changes in labour	4	0.6	5	0.8	28	4.2	339	51.4	250	37.9	34	5.2

Table 23 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
orientation to environment, staff and procedures	2	0.3	2	0.3	25	3.8	356	53.9	242	36.7	33	5.0
provision of comfort measures	3	0.5	2	0.3	18	2.7	285	43.2	319	48.3	32	4.9
promotion of privacy & respect	3	0.5	2	0.3	17	2.6	277	42.0	329	49.8	32	4.9
demonstration of breathing and relaxation methods	3	0.5	2	0.3	13	2.0	290	43.9	317	48.0	35	5.4
identification of hygiene, safety, social interaction/ support, knowledge, nutritional, oxygenation, elimination needs	3	0.5	2	0.3	14	2.1	309	46.8	301	45.6	31	4.8
development of client/family orientated birthing care plan	3	0.5	3	0.5	24	3.6	306	46.4	203	30.8	121	18.3
Augmentation Induction of Labour												
assessment of cervix for induction	254	38.5	15	2.3	80	12.1	88	13.3	19	2.9	204	31.0
artificial rupture of membranes	230	34.8	18	2.7	103	15.6	104	15.8	45	6.8	160	24.3
insertion of I.V. cannula	267	40.5	17	2.6	31	4.7	42	6.4	15	2.3	288	43.6
administration of oxytocin by infusion	82	12.4	47	7.1	262	39.7	185	28.0	14	2.1	70	10.6
identification of complications	19	2.9	13	2.0	69	10.5	325	49.2	180	27.3	54	8.2
referral to medical practitioner	29	4.4	10	1.5	58	8.8	287	43.5	162	24.5	114	17.3
implementation of emergency procedures	71	10.8	28	4.2	80	12.1	261	39.5	142	21.5	78	11.9

Table 23 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Pain Control												
administration of anaesthetic/analgesic drugs via 1. epidural route	247	37.4	17	2.6	103	15.6	83	12.6	13	2.0	197	29.8
2. inhalation	10	1.5	2	0.3	51	7.7	329	49.8	212	32.1	56	8.5
3. oral	12	1.8	3	0.5	192	29.1	230	34.8	101	15.3	122	18.5
4. intramuscular	13	2.0	7	1.1	335	50.8	211	32.0	55	8.3	39	5.9
5. subcutaneous	13	2.0	2	0.3	185	28.0	90	13.6	21	3.2	349	52.9
6. intravenous	80	12.1	24	3.6	232	35.2	102	15.5	15	2.3	207	31.4
pain control by a. acupuncture	24	3.6	0	0.0	1	0.2	10	1.5	16	2.4	609	92.3
b. hot bath	4	0.6	2	0.3	17	2.6	177	26.8	253	38.3	207	31.4
c. other methods	3	0.5	2	0.3	8	1.2	105	15.9	198	30.0	344	52.1
Assessment of Progress												
assessment of descent of presenting part	14	2.1	3	0.5	48	7.3	354	53.6	201	30.5	40	6.1
assessment of effacement and dilatation of cervix	67	10.2	14	2.1	106	16.1	261	39.5	145	22.0	67	10.1
assessment of complications	20	3.0	6	0.9	63	9.5	312	47.3	213	32.3	46	7.0

4.5.2.4.2 Second stage of labour

Throughout the second stage of labour there was an increase of medical input with intervention procedures. This included episiotomy, often performed by assisting a medical practitioner or under medical supervision (19.9%), but still performed without a medical practitioner present most frequently (58.8% of midwives). Other procedures showed a marked decrease in midwives' level of input and a corresponding increase in medical involvement and responsibility. For example: infiltration of the perineum with

local anaesthetic (28.2% performed at the level of assisting or performing under direct medical supervision); non rotational vacuum extraction (46% with 52.5% of midwives not performing at any level in the past 5 years); non rotational forceps delivery (57% with 41.2% not performing the procedure at any level); rotational forceps delivery (56.1% and 42.5%); and assisting at a Caesarean section being of necessity performed at the level of assisting the medical practitioner. There were 223 (33.8%) midwives involved in intrapartum care who had not assisted at a birth by Caesarean section in the past 5 years.

There was an observable trend with the conduction of individual deliveries by midwives within level 1, level 2 and level 3 service providing organisations. Of the 281 midwives working in level 1 intrapartum settings 40.9% had not conducted a delivery in the past 12 months. The remaining 166 averaged 19.41 conductions. Level 2 hospitals had a higher percentage (48.4%) who had not conducted a delivery in the past 12 months but the 214 midwives who had, averaged 33.6 deliveries. This trend continued at level 3 with a greater percentage again not participating in deliveries (62.8%) but the remaining 93 averaging 41 deliveries per midwife. The total number of spontaneous vaginal deliveries conducted by midwives during the past 12 months was estimated to be 14231, an average of 30 for each of the 473 midwives who had been involved in conducting normal deliveries in that time.

Table 23 Continued **2nd Stage Labour**												
SP = Self Performed P&P = Policies & Procedures MP = Medical Practitioner	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
recognition of transition from 1st to 2nd stage of labour	4	0.6	2	0.3	27	4.1	293	44.4	291	44.1	43	6.1
Preparation of Client / Family												
preparation of client/family for 2nd stage of labour	6	0.9	1	0.2	28	4.2	294	44.5	288	43.6	43	6.3

Table 23 Continued SP = Self Performed P&P = Policies & Procedures MP = Medical Practitioner	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
information giving and support to client/family	19	2.9	5	0.8	45	6.8	296	44.8	255	38.6	40	6.0
emotional preparation of client/family	11	1.7	4	0.6	29	4.4	262	39.7	313	47.4	41	6.2
physical preparation of client	7	1.1	3	0.5	47	7.1	351	53.2	208	31.5	44	6.7
preparation of environment and equipment	6	0.9	6	0.9	40	6.1	382	57.9	177	26.8	49	7.4
diagnosis of the second stage of labour	9	1.4	1	0.2	28	4.2	287	43.5	292	44.2	43	6.5
guiding expulsive maternal efforts	8	1.2	9	1.4	24	3.6	261	39.5	313	47.4	45	6.8
encouraging effective breathing and relaxation techniques	4	0.6	6	0.9	19	2.9	258	39.1	330	50.0	43	6.5
facilitating choice of maternal position	8	1.2	8	1.2	28	4.2	251	38.0	320	48.5	45	6.8
monitoring maternal well being	3	0.5	5	0.8	22	3.3	368	55.8	218	33.0	44	6.7
monitoring fetal well being	4	0.6	5	0.8	33	5.0	377	57.1	196	29.7	45	6.8
identification of failure to progress	25	3.8	15	2.3	61	9.2	305	46.2	199	30.2	55	8.3
conducting a spontaneous vaginal delivery	65	9.8	20	3.0	58	8.8	265	40.2	197	29.8	55	8.3
catheterisation	20	3.0	3	0.5	132	20.0	299	45.3	146	22.1	60	9.1
episiotomy	102	15.5	29	4.4	31	4.7	208	31.5	149	22.6	141	21.4
infiltration of the perineum with local anaesthetic agent	157	23.8	29	4.4	33	5.0	161	24.4	87	13.2	193	29.3
non rotational vacuum extraction	300	45.5	3	0.5	3	0.5	7	1.1	1	0.2	346	52.5
non rotational forceps delivery	374	56.7	2	0.3	4	0.6	6	0.9	2	0.3	272	41.2
rotational instrument delivery	368	55.8	2	0.3	3	0.5	6	0.9	1	0.2	280	42.5
assisting at Caesarean section	339	51.4	15	2.3	16	2.4	62	9.2	5	0.8	223	33.8

4.5.2.4.3 Third stage of labour

During the third stage of labour midwives perceived level of practice autonomy was rated as *following policies and procedures* (47.8%) or *autonomous decision making* (23.7%). Where complications arose, medical input increased and midwives acted more frequently in an assisting capacity. Examples of these complications and subsequent changes in level of practice autonomy included: manual removal of retained placenta (52% *performed assisting a medical practitioner* while 42.6% had not been involved in this procedure during the past 5 years); 73.7% of midwives had not been involved in emergency treatment following inversion of the uterus while 20% had assisted a medical practitioner in this emergency. Repair of perineal trauma was rated as *assisting the medical practitioner* by 332 midwives (50.3%). A further 18 (2.7%) performed the task *under direct medical supervision;* 11 (1.7%) did so *following the doctor's orders in their absence;* 32 (4.8%) performed *following policies and procedures,* 32 (4.8%) *performed autonomously,* and 251 (38.1%) midwives had not been involved in the procedure during the past 5 years.

The total number of responses indicating the perceived level of autonomy in the performance of specific intrapartum care procedures indicated that midwives usually practised following policies and procedures (f=19236=37.9%). Procedures performed independently i.e. autonomous decision making practice followed (f=11931=23.5%); procedures performed following direct medical instructions or assisting a medical practitioner (f=10620=20.9%), while procedures rated as not having been performed during the past 5 years had a frequency response of 8932 (17.6%).

Table 23 Continued MP =Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
administration of prophylactic oxytocics	7	1.1	41	6.2	80	27.3	307	46.5	70	10.6	55	8.3
cord cutting and clamping	45	6.5	23	3.5	33	5.0	333	50.5	173	26.2	53	8.0
controlled cord traction	49	7.4	19	2.9	31	4.7	325	49.2	172	26.1	64	9.7
identification of contributing causes of post partum haemorrhage	34	5.2	18	2.7	35	5.3	299	45.3	210	31.8	64	9.7

Table 23 Continued MP =Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
emergency treatment of post partum haemorrhage	89	13.5	27	4.1	77	11.1	250	37.9	121	18.3	96	14.5
conservative management of delayed expulsion of placenta	93	14.1	22	3.3	76	11.5	245	37.1	123	18.6	101	15.2
manual removal retained placenta	341	51.7	5	0.8	6	0.9	23	3.5	4	0.6	281	42.6
emergency treatment following inversion of the uterus	130	19.7	6	0.9	10	1.5	24	3.6	4	0.6	486	73.7
infiltration of local anaesthetic prior to repair of perineum	331	50.2	16	2.4	16	2.4	45	6.8	28	4.2	224	34.0
suturing of perineal trauma	332	50.3	18	2.7	11	1.7	32	4.8	32	4.8	251	38.1

The numerous factors involved in this wide dispersion of levels of practice autonomy will be discussed with reference to these findings in the chapters addressing the factors influencing the midwives' ability to practise within the WHO (1976) definition of the sphere of practice of the midwife as stated by the Australian College of Midwives (1989).

4.5.2.5 Midwives level of input to the development of the policies and procedures guiding intrapartum care

Midwives indicated their most usual level of autonomy in the performance of intrapartum care procedures as *self performed following organisational policies and procedures* (37.9%). In response to the question of what was their highest level of input to the development of these policies, 81.7% said they had indirect, little, or no input; 59 (8.9%) were involved in the direct preparation of policies and procedures, and 57 (8.6%) were involved in the determination of policies and procedures. Midwives employed in level 1 service providing organisations had more direct input to the development of intrapartum policies and procedures i.e. level 1=23.4%, level 2=16.7% and level 3=15.6%. Table 24 (pp.101-102) illustrates in more detail the level of input midwives

perceived they had in the development of policies and procedures. This was in relation to the intrapartum practice settings in which they had been employed during the past five years.

Table 24 Relationship Between Input to Policies and Procedures and Midwives Intrapartum Employment Settings.

SETTING	No Input		Little Input		Indirect Input		Direct Input		Determine Policies & Procedure	
	f	%	f	%	f	%	f	%	f	%
Specialist obstetric public hospital inpatient care n=280	78	27.9	64	2.9	88	31.4	24	8.6	26	9.3
Specialist obstetric private hospital inpatient care n=106	33	31.1	16	15.1	42	39.6	10	9.4	5	4.7
Specialist obstetric public & private hospital inpatient care n=103	29	28.2	29	28.2	34	33.0	4	3.9	7	6.8

Note - 171 (25.9%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
G P public hospital inpatient care n=315	60	19.0	19	26.0	116	36.8	33	10.5	34	10.4
G P private hospital inpatient care n=73	19	26.0	16	21.9	24	32.9	8	11.0	6	8.2
G P public and private hospital inpatient care n=74	16	21.6	19	25.7	30	40.5	4	5.4	5	6.8

Note - 198 (30.0%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
Public birth centre n=58	10	17.2	10	17.2	23	39.7	9	15.5	6	10.3
Private birth centre n=17	1	5.9	6	35.3	8	47.1	1	5.9	1	5.9
Public & private birth centres n=9	2	22.2	2	22.2	2	22.2	1	11.1	2	22.2

Note - 576 (87.2%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

SETTING	No Input f	No Input %	Little Input f	Little Input %	Indirect Input f	Indirect Input %	Direct Input f	Direct Input %	Determine Policies & Procedure f	Determine Policies & Procedure %
Public alternative birthing suite n=69	9	13.0	18	26.1	28	40.6	6	8.7	8	11.6
Private alternative birthing suite n=38	5	13.2	8	21.1	14	36.8	9	23.7	2	5.3
Public & private alternative birthing suite n=21	1	12.5	3	37.5	2	25.0	1	12.5	1	12.5

Note - 532 (80.6%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
Publicly employed domiciliary setting n=21	4	19.0	8	38.1	4	19.0	1	4.8	4	19.0
Privately employed domiciliary setting n=10	0	0.0	1	10.0	4	40.0	1	10.0	4	40.0
Publicly & privately employed domiciliary setting n=6	0	0.0	2	33.3	3	50.0	0	0.0	1	16.7

Note - 623 (94.3%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
Public other setting n=14	5	35.7	4	28.6	3	21.4	2	14.3	0	0.0
Private other setting n=9	1	11.1	2	22.2	3	33.3	0	0.0	3	33.3
Public & private other setting n=3	1	33.3	2	66.6	0	0.0	0	0.0	0	0.0

Note - 634 (96.1%) of midwives providing intrapartum care had not been employed in these settings during the past 5 years.

4.5.2.6 Liaison with other health professionals

A linear relationship was evident with the frequency of nominated liaison with specific health professionals in the provision of intrapartum care, as identified with antenatal care. Again the general practitioner was more frequently nominated in level 1 settings (88.5%) in comparison with 73.9% in level 2 settings and 57.2% in level 3. As the liaison decreased with the general practitioners it increased with the specialist obstetricians. There were 52% of intrapartum practising midwives who said they liaised with specialist obstetricians in level 1 settings; 88.3% in level 2 settings and 89.6% in level 3 settings.

Table 25 Midwives Intrapartum Liaision With the Medical Profession by Levels.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
General Practitioner	208	88.5	252	73.9	99	57.2
Specialist Obstetrician	124	52.8	301	88.3	155	89.6
Paediatrician	97	41.3	248	72.7	135	78.0
Anaesthetist	112	47.7	246	72.1	135	78.0
Other Medical Personnel	2	0.9	12	3.5	16	9.2

The frequencies of midwives nominating the health professionals they liaised with in the provision of intrapartum care are shown in Table 26 (p.104).

Table 26 Midwives Intrapartum Liaision With Other Health Professionals by Levels.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Physiotherapist	63	26.8	87	25.5	53	30.6
Social Worker	32	13.6	75	22.0	65	37.6
Dietitian	27	11.5	54	15.8	31	17.9
Pharmacist	39	16.6	84	24.6	44	25.4
Pathologist	58	24.7	109	32.0	58	33.5
Radiologist	29	12.3	62	18.2	33	19.1
Minister of Religion	29	12.3	64	18.8	56	32.4
Psychologist	10	4.3	16	4.7	13	7.5
Occupational Therapist	2	0.9	5	1.5	6	3.5
Other Health Professional	5	2.1	8	2.3	6	3.5

Apart from one instance (physiotherapist) there was increasing liaison between midwives and other health professionals related to the increase in the level of service provided.

4.5.2.7 Utilisation of midwifery knowledge and skills in providing intrapartum care

The majority of midwives practising intrapartum care considered their knowledge and skills were, utilised most of the time, well utilised, or fully utilised (81.6% for knowledge utilisation and 78.8% for utilisation of skills). Tables 27 and 28 (p.105) indicate midwives' perceptions of the levels of utilisation. Midwives working in level 3 settings expressed the greatest range in their estimates of utilisation of skills and knowledge with 6.9% stating their skills were not utilised and 12.7% saying they were fully utilised. Only .9% and 2.1% of level 1 and level 2 said their skills were not utilised, while 9.4% and 8.2% respectively, felt their skills were fully utilised.

Table 27 Utilisation of Midwives' Intrapartum Knowledge (by Hospital Levels.)

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	0	0.0	3	0.9	5	2.9
Poorly utilised	36	15.3	45	13.2	27	15.6
Utilised most of time	82	34.9	126	37.0	59	34.1
Well utilised	93	39.6	124	36.4	57	32.9
Fully utilised	21	8.9	30	8.8	23	13.3

Table 28 Utilisation of Midwives' Intrapartum Skills (by Hospital Levels.)

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	2	0.9	7	2.1	12	6.9
Poorly utilised	41	17.4	48	14.1	28	16.2
Utilised most of time	81	34.5	123	36.1	56	32.4
Well utilised	86	36.6	122	35.8	53	30.6
Fully utilised	22	9.4	28	8.2	22	12.7

4.5.2.8 Satisfaction with the division of responsibility within the health care team

Of the 660 midwives practising in intrapartum care 137 (20.7%) said that they had little or no satisfaction with the division of responsibility in the health care team for providing intrapartum care. The majority (332 = 50.3%) said they were mostly satisfied; 151 (22.9%) were well satisfied and 20 (3%) were highly satisfied. Midwives working in level 3 settings expressed dissatisfaction more frequently than levels 1 and 2 but they were also more frequently highly satisfied. Levels of satisfaction with the division of responsibility within the intrapartum care team are indicated in Table 29 (p.106).

Table 29 Satisfaction With Division of Responsibility for Intrapartum Care.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Dissatisfied	4	1.7	8	2.3	9	5.2
Little satisfaction	42	17.9	66	19.4	32	18.5
Mostly satisfied	114	48.5	167	49.0	80	46.2
Well satisfied	64	27.2	79	23.2	39	22.5
Highly satisfied	8	3.4	7	2.1	10	5.8

4.5.3 Postnatal practice

This study refers to the postnatal period as the six weeks commencing at the completion of the third stage of labour. This six week period following childbirth is also called the puerperium. Findings of this study indicate that there were more midwives employed in providing postnatal care than either antenatal or intrapartum care (n=795).

4.5.3.1 Postnatal practice settings

Of the 795 midwives who had been employed in postnatal care during the past five years there were 269 who had worked in level 1 settings, 387 at level 2 and 227 at level 3. As with antenatal and intrapartum care midwives may have provided midwifery care at any level while employed in a level 3 setting. In level 1 and level 2 service providing organisations midwives were also required to function at different levels during emergencies. This accounts for midwives in all levels indicating their involvement in what could be considered level 3 only type procedures. Similarly, this is demonstrated in the postpartum task analysis (Table 34 pp.110-121). Midwives may also have worked in more than one setting during this period of time.

Table 30 Postnatal Practice Settings n = 795

	PUBLIC		PRIVATE		B O T H		NOT DONE	
Specialist obstetrician hospital care	329	41.4%	125	15.7%	131	16.5%	208	26.2%
General practitioner hospital care	334	42.0%	81	10.2%	81	10.2%	298	37.5%
Birth centre	56	7.0%	11	1.4%	10	1.3%	716	90.1%
Alternative birth suite	54	6.8%	24	3.0%	8	1.0%	707	88.9%
Domiciliary setting	62	7.8%	11	1.4%	7	0.9%	713	89.7%
Other	52	6.5%	9	1.1%	2	0.3%	730	91.8%

In response to the question asking midwives to indicate their postnatal practice settings 585 (73.6%) said they had provided postnatal care at a *specialist obstetrician* hospital; 496 (62.4%) at a *general practitioner* hospital; 77 (9.7%) at a birth centre; 86 (10.8%) at an alternative birthing suite attached to a labour ward; 80 (10.1%) had provided postnatal care in a domiciliary setting, and 63 (7.9%) indicated they had provided postnatal care at other settings. Tables 30, 31, 32 and 33 (pp. 107-108) show the dispersal of midwives throughout public and private settings and model of care provided within postnatal settings at levels 1,2 and 3 respectively.

Comparison between the public and private settings providing levels 1, 2 or 3 services indicated midwives working in level 1 settings in both public and private maternity health services were less likely to work with specialist obstetricians than those in levels 2 or 3.

Midwives providing care in birth centres and alternative birthing suites were most frequently working in public health services (245) compared with 61 in private settings. These models of care were also most frequently provided within level 2 and 3 settings.

Table 31 Postnatal Practice Settings Level 1 n = 269 (33.8%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	67	24.9%	40	14.9%	36	13.4%	126	46.8%
General practitioner hospital care	149	55.4%	27	10.0%	34	12.6%	59	21.9%
Birth centre	14	5.2%	2	0.7%	3	1.1%	249	92.6%
Alternative birth suite	17	6.3%	7	2.6%	4	1.5%	240	89.2%
Domiciliary setting	19	7.1%	4	1.5%	3	1.1%	242	90.0%
Other	18	6.7%	4	1.5%	0	0.0%	246	91.4%

Table 32 Postnatal Practice Settings Level 2 n = 387 (48.7%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	186	48.1%	81	20.9%	73	18.9%	47	12.1%
General practitioner hospital care	167	43.2%	51	13.2%	45	11.6%	124	32.0%
Birth centre	25	6.5%	8	2.1%	4	1.0%	350	90.4%
Alternative birth suite	31	8.0%	19	4.9%	5	1.3%	332	85.8%
Domiciliary setting	29	7.5%	5	1.3%	2	0.5%	351	90.7%
Other	17	4.4%	3	0.8%	0	0.0%	367	94.8%

Table 33 Postnatal Practice Settings Level 3 n = 227 (28.6%)

	PUBLIC		PRIVATE		B O T H		NEITHER	
Specialist obstetrician hospital care	126	55.5%	17	7.5%	63	27.8%	21	9.2%
General practitioner hospital care	69	30.4%	10	4.4%	19	8.4%	129	56.8%
Birth centre	28	12.3%	2	0.9%	7	3.1%	190	83.7%
Alternative birth suite	16	7.0%	4	1.8%	3	1.3%	204	89.9%
Domiciliary setting	17	7.5%	2	0.9%	3	1.3%	205	90.3%
Other	14	6.2%	1	0.4%	1	0.4%	211	93.0%

4.5.3.2 Practice area

The majority of midwives providing postpartum care had been involved in clinical practice (747 = 94%). There were 605 (76.1%) who indicated their postnatal care involved postnatal education for the clients; 207 (26%) were involved in education for midwives; 149 (18.7%) in the management of postnatal services, and 77 (9.7%) had been involved in postnatal research.

4.5.3.3 Involvement of families of childbearing women

Of the 795 midwives who had been involved in postnatal midwifery practice during the past five years, 641 (80.6%) indicated their practice had included the families of the childbearing women. There were 138 (17.4%) who said they had not been involved with the families, and there were 16 (2%) missed responses.

4.5.3.4 Level of autonomy of practice

The most usual levels of practice autonomy during postnatal task performance have been analysed within nine stages or settings of care (Table 34 pp.110-121). These are described in order as: *immediate postpartum care; continued monitoring (maternal); identification and treatment of complications (maternal); provision of education/information; assessment of infant - first hour of life; family support; infant care 2 hours - 3 days; domiciliary postnatal care; and child health services.* Postnatal tasks and the level of practice autonomy are presented within these stages and settings.

4.5.3.4.1 Immediate postpartum care

There were 18 tasks (or procedures) identified as being performed during the immediate postpartum period of 1 - 2 hours. Midwives' combined perceptions of their most usual level of autonomy in the performance of these procedures were rated in order of frequency (f) as: *self performed following organisational policies and procedures* (f=6113=42.7%); *practised independently i.e. autonomous decision making* (f=4060=28.4%); *not done during the past five years* (f=1794=12.54%); *self performed under indirect supervision of a medical practitioner following verbal orders* (f=1441=10.07%); *assisted with procedure performed by medical practitioner* (f=725=5%); and *self performed under direct supervision of a medical practitioner present at the time* (f=172=1.2%).

The only procedure rated by midwives as being most usually performed at the level of assisting the medical practitioner during the immediate postpartum stage was *the initiation of intravenous therapy.* There were 39.4% of midwives' responses that indicated this level of performance for this procedure; 27.3% said *they had not done this procedure in the past 5 years;* 14.1% had *self performed following organisational policies and procedures;* 14% *self performed under indirect supervision of medical practitioner following verbal or written orders;* 3% had most usually performed the procedure *practising independently i.e. autonomously;* and 2.3% had most usually *self performed under direct supervision of a medical practitioner present at the time.*

There were two other procedures during the immediate postpartum period where a significant number of midwives indicated they most usually performed the procedures by assisting the medical practitioner. These procedures were *assessment of trauma to cervix, vagina and perineum* 20.5%, and *preparation for evacuation of uterus or surgical intervention* 23.3%.

Detailed frequencies and percentage rates for the most usual level of practice for procedures performed during the immediate postpartum period are provided in Table 34 (pp. 110-111).

Table 34 Most Usual Level of Postnatal Task Performance

n=795

MP = Medical Practitioner SP = Self Performed P&P=Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Immediate Postpartum Care												
assessment of vital signs	4	0.5	4	0.5	32	4.0	497	62.5	188	23.6	70	8.8
monitoring uterine consistency and location	4	0.5	1	0.1	26	3.3	483	60.8	209	26.3	72	9.0
monitoring nature and rate of lochial flow	2	0.3	3	0.4	22	2.8	480	60.4	215	27.0	73	9.2

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P=Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
monitoring fluid volume	2	0.3	4	0.5	60	7.5	467	58.7	170	21.4	92	11.0
identification of post partum haemorrhage	6	0.8	9	1.1	33	4.2	390	49.1	250	31.4	107	13.4
fundal massage	3	0.4	8	1.0	36	4.5	387	48.7	271	34.1	90	11.3
administration of oxytocin or ergot preparations	12	1.5	41	4.2	293	36.9	265	33.3	54	6.8	130	16.4
initiation of intravenous therapy	313	39.4	18	2.3	111	14.0	112	14.1	24	3.0	217	27.3
bladder catheterisation	14	1.8	12	1.5	254	31.9	295	37.1	100	12.6	120	15.1
assessment of trauma to cervix vagina and perineum	163	20.5	31	3.9	62	7.8	280	35.2	113	16.2	146	18.4
preparation for evacuation of uterus or surgical intervention	185	23.3	26	3.3	120	15.1	218	27.4	35	4.4	211	26.5
assessment of nature and degree of discomfort	5	0.6	5	0.6	26	3.3	352	44.3	331	41.6	76	9.6
application of ice pack to perineum	3	0.4	1	0.1	14	1.8	308	38.7	393	49.4	76	9.6
provision of comfort and hygiene measures	1	0.1	2	0.3	12	1.5	311	39.1	401	50.4	68	8.6
administration of analgesia	3	0.4	7	0.9	298	37.5	259	32.6	156	19.6	72	9.1
assessment of family processes and informational needs	2	0.3	2	0.3	16	2.0	341	42.9	365	45.9	69	8.7
encouragement of family bonding attachment processes	2	0.3	1	0.1	13	1.6	310	39.0	415	52.2	54	6.8
facilitation of early breast feeding	1	0.1	2	0.3	13	1.6	358	45.0	370	46.5	51	6.5

4.5.3.4.2 Continued monitoring (maternal)

Medical participation in the continued monitoring of maternal condition following the immediate postpartum period was perceived by midwives to be minimal. There were 6 monitoring procedures analysed for level of autonomous practice in the continued monitoring of maternal postpartum status. The most frequently nominated level of performance by midwives involved in postnatal practice was *self performed following organisational policies and procedures* (f=2807=57.6%). This was followed by *practised independently i.e. autonomous decision making* (f=1504=30.9%); *procedure not done in the past 5 years* (f=406=8.3%); *self performed under indirect supervision of a medical practitioner following his/her verbal or written orders* (f=107=2.2%); *assisted with procedure performed by medical practitioner* (f=39=.8%), and *self performed under direct supervision of medical practitioner* (f=7=.1%).

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Continued Monitoring of -:												
vital signs	1	0.1	1	0.1	18	2.3	504	63.4	204	25.7	67	8.4
fundus and lochia	1	0.1	1	0.1	16	2.0	500	62.9	316	27.2	61	7.6
breast comfort	1	0.1	1	0.1	13	1.6	448	56.4	279	35.1	53	6.7
perineum	1	0.1	1	0.1	14	1.8	467	58.7	253	31.8	59	7.5
discomfort or swelling of the lower extremities	2	0.3	1	0.1	18	2.3	454	57.1	249	31.3	71	8.9
surgical incision	33	4.2	2	0.3	28	3.5	434	54.6	203	25.5	95	12.0

4.5.3.4.3 Identification and treatment of complications (maternal)

Midwives were asked to rate their most usual level of practice in relation to the identification and treatment of eight complications that could occur during the postpartum period. Complications included haemorrhage, infection, disease processes, excessive breast engorgement, mastitis, cracked/painful nipple, emotional instability and psycho/social problems. The overall ratings for the identification and treatment of these conditions was: *self performed following organisational policies and procedures*

(f=2859=45%); *practised independently i.e. autonomous decision making* (f=1584=24.9%); *self performed under indirect supervision of a medical practitioner following his/her verbal or written orders* (f=1068=16.8%); *procedure not performed during the last 5 years* (f=583=9.1%); *assisted with procedure performed by a medical practitioner* (f= 193=3%); *self performed under direct supervision of medical practitioner* (f=73=1.1%).

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Identification and Treatment of Complications												
haemorrhage	55	6.9	11	1.4	14217.9		346	43.5	147	18.5	94	11.9
infection	36	4.5	19	2.4	230	28.9	317	39.9	122	15.3	71	9.0
disease processes	43	5.4	18	2.3	197	24.8	313	39.4	113	14.2	111	14.0
excessive breast engorgement	4	0.5	0	0.0	41	5.2	429	54.0	269	33.8	52	6.5
mastitis	23	2.9	11	1.4	202	25.4	325	40.9	154	19.4	80	10.1
cracked/painful nipple	2	0.3	0	0.0	22	2.8	450	56.6	273	34.3	48	6.0
emotional instability	13	1.6	5	0.6	120	15.1	340	42.8	258	32.5	59	7.5
psycho/social problems	17	2.1	9	1.1	114	14.3	339	42.6	248	31.2	68	8.6

4.5.3.4.4 Provision of education/information

As illustrated in Table 34 (p.114), midwives did not consider that the education and information they provided for the women was performed in the presence of a medical practitioner. There were a minimal number of responses indicating that education/information was provided following a medical practitioner's orders (f=100=2.5%). There was a 261 frequency response (2.5%) to the combined five procedures rated as *not done during the past 5 years.* This was an area of practice where midwives perceived they had more autonomy in their practice. There were 1290 (32.4%) ratings for providing education/information at the *independent practice or autonomous*

decision making level, and 2307 (58%) ratings of *followed organisational procedures and policies.*

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Provision of Education/ Information for :-												
postnatal self care	2	0.3	1	0.1	19	2.4	440	55.3	283	35.6	50	6.3
breast feeding	2	0.3	1	0.1	17	2.1	458	57.6	275	34.6	42	5.3
formula feeding	3	0.4	1	0.1	22	2.8	482	60.6	231	29.1	56	7.0
infant care	3	0.4	1	0.1	22	2.8	459	57.7	264	33.2	46	5.8
community support services	2	0.3	1	0.1	20	2.5	468	58.9	237	29.8	67	8.5

4.5.3.4.5 Assessment of newborn infant

There were 17 procedures pertaining to the first hours of the newborn infant's life. The most frequently nominated level of practice overall for these procedures was *self performed following organisational policies and procedures* (f=5883=43.5%). This was followed by *not practised during the past five years* (f=2660=19.7%); *practised independently* (f=2440=18%); *self performed under indirect supervision of a medical practitioner following his/her verbal or written orders* (f=1234=9.1%); 6.4% said they usually assisted a medical practitioner perform the procedures and 3.3% performed the procedures under the direct supervision of a medical practitioner present at the time.

Of the seventeen procedures performed during the first few hours of life there were three that midwives rated as most usually having more input from medical practitioners than the remaining 14 procedures. These were *ordering laboratory tests, determining withholding or discontinuing resuscitation, preparation for transfer to intensive care.* Table 34 (p.115) provides details of the frequencies and percentages for specific procedures.

Table 34 Continued

MP = Medical Practitioner
SP = Self Performed
P&P = Policies & Procedures

	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Assessment of Infant First Hour of Life :-												
assessment of relevant maternal /family history	9	1.1	7	0.9	30	3.8	479	60.3	174	21.9	9	12.2
assessment of relevant prenatal history	10	1.3	5	0.6	28	3.5	484	60.9	171	21.5	97	12.2
assessment of intrapartal history	7	0.9	3	0.4	34	4.3	484	60.9	168	21.1	99	12.5
apgar scoring	4	0.5	12	1.5	31	3.9	454	57.1	183	23.0	111	14.0
assessment of vital signs	1	0.1	4	0.5	20	2.5	480	60.4	197	24.8	93	11.7
physical examination	36	4.5	9	1.1	29	3.6	455	57.2	167	21.0	99	12.5
detection of abnormalities	32	4.0	12	1.5	38	4.8	430	54.1	179	22.5	104	13.1
collection of cord blood for diagnostic purposes	34	4.3	8	1.0	54	6.8	425	53.5	122	15.3	152	19.1
ordering laboratory tests	148	18.6	32	4.0	260	32.7	141	17.7	23	2.9	191	24.0
clearance of airway	14	1.8	27	3.4	38	4.8	368	46.3	239	30.1	109	13.8
suctioning of gastric contents	27	3.4	24	3.0	89	11.2	337	42.4	163	20.5	155	19.5
maintenance of body temperature	1	0.1	7	0.9	21	2.6	431	54.2	247	31.1	88	11.1
administration of oxygen	10	1.3	32	4.0	120	15.1	347	43.6	184	23.1	102	12.8
administration of naloxone	50	6.3	66	8.3	221	27.8	185	23.3	59	7.4	214	26.9
provision of C P R	98	12.3	47	5.9	48	6.0	173	21.8	118	14.8	311	39.1
determining withholding or discontinuing resuscitation	196	24.7	54	6.8	59	7.4	50	6.3	11	1.4	425	53.5
preparation for transfer to intensive care	178	22.4	94	11.8	114	14.3	160	20.1	35	4.4	214	27.0

4.5.3.4.6 Family support

Midwives perceived themselves to perform the five procedures of family support with minimal input from medical practitioners. The greatest percentage (51.4%) said that they practised *following organisational policies and procedures* while performing the procedures of *maintenance of safety, informing parents of rationale for care procedures, promotion of attachment and acceptance, facilitation of parent infant interaction, supporting parents and families affected by infant morbidity and mortality.* A further 35.7% said they practised these procedures independently; 9.3% had not practised these procedures during the past five years; 2.7% *self performed under indirect supervision of a medical practitioner* and 0.8% *assisted with procedure performed by a medical practitioner* (Table 34 below).

Table 34 Continued

MP = Medical Practitioner
SP = Self Performed
P&P = Policies & Procedures

	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Family Support :-												
maintenance of safety	2	0.3	4	0.5	22	2.8	455	57.2	247	31.1	65	8.2
informing parents of rationale for care procedures	2	0.3	1	0.1	25	3.1	453	57.0	255	32.1	59	7.4
promotion of attachment and acceptance	1	0.1	1	0.1	16	2.0	401	50.4	317	39.9	59	7.4
facilitation of parent infant interaction	1	0.1	1	0.1	16	2.0	383	48.2	336	42.3	58	7.3
supporting parents / families affected by infant morbidity / mortality	6	2.0	6	0.8	29	3.6	352	44.3	263	33.1	129	16.3

4.5.3.4.7 Infant care 2 hours to 3 days

Thirty seven procedures were considered as being the major components of the care provided to the newborn, in conjunction with the infant's mother, during this period. With the exception of *monitoring arterial blood gases, ordering and reviewing chest x-ray, and initiating intravenous therapy*, procedures were most usually performed *following policies and procedures* f=13146=44.7%); *independently i.e. autonomous decision making* (f=5713=19.4%); *not done in past five years* f=4638=15.8%); *self performed under indirect supervision of a medical practitioner following verbal or written orders* (f=3361=11.4%); *assisted with procedure performed by medical practitioner* (f=2157=7.3%), and *self performed under direct supervision of medical practitioner present at the time* f=2157=7.3%). (Table 34 pp.117-119).

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Infant Care 2 hrs - 3 days												
maintenance of thermoneutral environment	2	0.3	0	0.0	24	3.0	482	60.6	235	29.6	52	6.6
assessment for hyper/hypo thermia	3	0.4	0	0.0	22	2.8	489	61.5	230	28.9	51	6.5
detection of abnormalities	30	3.8	8	1.0	33	4.2	444	55.8	222	27.9	58	7.4
monitoring and assessment for disease processes	44	5.5	9	1.1	86	10.8	430	54.1	145	18.2	81	10.3
referral to paediatrician	136	17.1	25	3.1	164	20.6	246	30.9	91	11.4	133	16.8
obtaining specimens for cultures	81	10.2	21	2.6	269	33.8	254	31.9	65	8.2	105	13.2
administration of sedatives oral IM IV or SC	42	5.3	31	3.1	350	44.0	136	17.1	17	2.1	219	27.5
administration of antibiotics oral IM IV SC or topical	30	3.8	22	2.8	446	56.1	172	21.6	24	3.0	101	12.7

Table 34 Continued

MP = Medical Practitioner
SP = Self Performed
P&P = Policies & Procedures

	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
assessment of respiratory rate and effort	10	1.3	3	0.4	42	5.3	448	56.4	211	26.5	81	10.2
maintenance of clear airway	15	1.9	3	0.4	38	4.8	425	53.5	247	31.1	67	8.4
auscultation and assessment of breath sounds	51	6.4	12	1.5	46	5.8	396	49.8	197	24.8	83	11.7
observation and recording signs of respiratory distress	7	0.9	6	0.8	47	5.9	449	56.5	220	27.7	66	8.3
assessment of presence, location and degree of cyanosis	20	2.5	6	0.8	44	5.5	408	51.3	241	30.3	76	9.5
auscultation and assessment of heart sounds	83	10.4	20	2.5	52	6.5	349	43.9	163	20.5	128	16.1
monitoring and evaluation of supplemental oxygen administration	42	5.3	21	2.6	188	23.6	317	39.9	90	11.3	137	17.3
monitoring arterial blood gases	217	27.3	19	2.3	68	8.6	76	9.6	13	1.6	402	50.6
assessment of Hb and Hct levels	211	26.5	24	3.0	96	12.1	78	9.8	14	1.8	372	46.8
ordering chest x-ray	223	28.1	39	4.9	144	18.1	28	3.5	2	0.3	359	45.2
reviewing chest x-ray	277	34.8	46	5.8	39	4.9	36	4.5	7	0.9	390	49.0
weighing infant	2	0.3	2	0.3	20	2.5	501	63.0	223	28.1	47	5.9
monitoring blood glucose levels	9	1.1	3	0.4	168	21.1	392	49.3	139	17.5	84	10.6
identification of hypoglycaemia	11	1.4	3	0.4	74	9.3	429	54.0	191	24.0	87	11.0
initiation of oral feedings breast, gastric tube, bottle	6	0.8	4	0.5	87	10.9	436	54.8	207	26.0	55	7.0

Table 34 Continued

MP = Medical Practitioner
SP = Self Performed
P&P = Policies & Procedures

	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
monitoring assessment of fluid balance	10	1.3	6	0.8	65	8.2	474	59.6	169	21.3	71	9.0
identification of feeding problems	4	0.5	4	0.5	25	3.1	393	49.4	322	40.5	47	5.9
initiation of IV therapy	369	46.4	17	2.1	81	10.2	38	4.8	9	1.1	281	35.4
monitoring IV therapy	33	4.2	10	1.3	150	18.9	356	44.8	79	9.9	167	21.1
prevention of cross infection	4	0.5	2	0.3	18	2.3	519	65.3	202	25.4	50	6.2
cord care	3	0.4	1	0.1	19	2.4	527	66.3	203	25.5	42	5.4
assessment of jaundice	10	1.3	5	0.6	48	6.0	460	57.9	224	28.2	48	6.1
administration of vitamin K	9	1.1	3	0.4	185	23.3	443	55.7	101	12.7	54	6.8
heel stick testing for PKU	2	0.3	1	0.1	43	5.4	557	70.1	132	16.6	60	7.6
assessment of bowel sounds	76	9.6	14	1.8	58	7.3	296	37.2	141	17.7	210	26.3
monitor establishment of elimination process	13	1.6	2	0.3	25	3.1	448	56.4	216	27.2	91	11.4
identification of gastro intestinal malfunction	63	7.9	7	0.9	70	8.8	314	39.5	168	21.1	173	21.8
parent education in infant care	4	0.5	1	0.1	12	1.5	450	56.6	279	35.1	49	6.2
provision of information regarding support services	5	0.6	2	0.3	15	1.9	450	56.6	262	33.0	61	7.7

4.5.3.4.8 Domiciliary postnatal care and Child Health Services

The greater percentage of midwives had not practised these procedures during the past five years. There were 58.9% who had not performed domiciliary post natal care and 77.8% who had not been involved in Child Health Services. Of those midwives who had provided these aspects of postnatal care there was minimal input from medical practitioners (Table 34 pp.120-121).

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
Domiciliary P N Care												
home visits during 1st ten days post delivery	0	0.0	2	0.3	8	1.0	133	16.7	75	9.4	577	72.5
post natal maternal care	1	0.1	1	0.1	12	1.5	230	28.9	129	16.2	422	53.2
post natal infant care	0	0.0	2	0.3	14	1.8	233	29.3	127	16.0	419	52.8
identification of complications	2	0.3	0	0.0	15	1.9	193	24.3	160	20.1	425	53.5
parent education	2	0.3	1	0.1	13	1.6	203	25.5	162	20.4	414	52.1
referral to community nursing service	2	0.3	1	0.1	23	2.9	203	25.5	140	17.6	426	53.6
referral to Medical Practitioner	10	1.3	2	0.3	32	4.0	165	20.8	125	15.7	461	58.0
referral to Allied Health	4	0.5	0	0.0	26	3.3	82	10.3	82	10.3	601	75.6
Child Health Services												
home visits	2	0.3	0	0.0	5	0.6	80	10.1	62	7.8	646	81.2
conducting child health clinics for infants up to 1 yr.	3	0.4	1	0.1	2	0.3	55	6.9	35	4.4	699	88.0
conducting child health clinics for infants up to 5 yrs.	2	0.3	0	0.0	2	0.3	51	6.4	36	4.5	704	88.5
promoting family focused health	3	0.4	0	0.0	2	0.3	92	11.6	84	10.6	614	77.1
provision of illness prevention measures	2	0.3	0	0.0	4	0.5	105	13.2	89	11.2	595	74.8
advising on contraception	7	0.9	0	0.0	10	1.3	168	21.1	162	20.4	448	56.3

Table 34 Continued MP = Medical Practitioner SP = Self Performed P&P = Policies & Procedures	Assisted MP		SP MP Present		SP on MP Direct Orders		SP Following P&P		Autonomy in Making Decisions		Not Done in past five years	
	f	%	f	%	f	%	f	%	f	%	f	%
administer immunisation	10	1.3	1	0.1	35	4.4	96	12.1	27	3.4	626	78.7
monitor development of infant	4	0.5	0	0.0	3	0.4	84	10.6	51	6.4	653	82.2
assist with family planning	7	0.9	1	0.1	12	1.5	102	12.8	88	11.1	585	73.6

4.5.3.5 Midwives level of input to the development of postnatal care policies and procedures

The most usual level of autonomy in the performance of postnatal care procedures was indicated by midwives as *self performed following organisational policies and procedures* (46.8%). In response to the question of what was their highest level of input to the development of these policies 81.3% said they had indirect, little, or no input; 75 (9.4%) were involved in the direct preparation of policies and procedures, and 71 (8.9%) were involved in the determination of policies and procedures. Table 35 (pp.122-124) illustrates in more detail the level of input midwives considered themselves to have had in the development of policies and procedures within the postpartum practice settings they had been employed in during the past five years.

These findings demonstrate midwives providing care in public *general practitioner services* were more involved in determining policies and procedures than those in public *specialist obstetrician services.* Midwives in both these public settings were more involved than those in private settings.

Table 35 Relationship Between Input to Postnatal Policies and Procedures and Midwives Employment Settings.

SETTING	No Input		Little Input		Indirect Input		Direct Input		Determine Policies & Procedure	
	f	%	f	%	f	%	f	%	f	%
Specialist obstetric public hospital inpatient care n=329	67	20.4	67	20.4	143	43.5	33	10.0	19	5.8
Specialist obstetric private hospital inpatient care n=125	17	13.6	30	24.0	62	49.6	9	7.2	7	5.6
Specialist obstetric public & private hospital inpatient care n=131	24	18.3	39	29.8	46	35.1	9	6.9	13	9.9

Note - 210 (26.4%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
G P public hospital inpatient care n=334	57	17.1	75	22.5	131	39.2	37	11.1	34	10.2
G P private hospital inpatient care n=81	12	14.8	22	27.2	33	40.7	8	9.9	6	7.4
G P public and private hospital inpatient care n=81	17	21.0	21	25.9	26	32.1	5	6.2	12	14.8

Note - 299 (37.6%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

Table 35 Continued SETTING	No Input f	%	Little Input f	%	Indirect Input f	%	Direct Input f	%	Determine Policies & Procedure f	%
Public birth centre n=56	12	21.4	10	17.9	22	39.3	6	10.7	6	10.7
Private birth centre n=11	0	0.0	4	36.4	6	54.5	0	0.0	1	9.1
Public & private birth centres n=10	1	10.0	2	20.0	4	40.0	0	0.0	3	10.0

Note - 718 (90.3%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
Public alternative birthing suite n=54	6	11.1	13	24.1	23	42.6	7	13.0	5	9.3
Private alternative birthing suite n=24	0	0.0	8	33.3	10	41.7	3	12.5	3	12.5
Public & private alternative birthing suites n=8	1	12.5	2	25.0	2	25.0	2	25.0	1	12.5

Note - 709 (89.2%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

	f	%	f	%	f	%	f	%	f	%
Publicly employed domiciliary setting n=62	6	9.7	10	16.1	30	48.4	7	11.3	9	14.3
Privately employed domiciliary setting n=11	0	0.0	1	9.1	4	36.4	3	27.3	3	27.3
Publicly & privately employed domiciliary setting n=7	4	57.1	0	0.0	3	42.9	0	0.0	0	0.0

Note - 715 (89.9%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

Table 35 Continued SETTING	No Input f %	Little Input f %	Indirect Input f %	Direct Input f %	Determine Policies & Procedure f %
Public other setting n=52	8 15.4	6 11.5	24 46.2	6 11.5	8 15.4
Private other setting n=9	1 11.1	4 44.4	2 22.2	1 11.1	1 11.1
Public & private other Setting n=2	0 0.0	1 50.0	1 50.0	0 0.0	0 0.0

Note - 734 (92.3%) of midwives providing postnatal care had not been employed in these settings during the past 5 years.

4.5.3.6 Liaison with other health professionals

The same linear relationship was evident with the frequency of nominated liaison with specific health professionals in the provision of postnatal, intrapartum care and antenatal care. Again the general practitioner was the only practitioner more frequently nominated in level 1 settings (85.5%) in comparison with 74.7% in level 2 settings and 59.5% in level 3. As the liaison decreased with the general practitioners there was increased liaison with the specialist obstetricians. There were 53.5% of postnatal practising midwives who said they liaised with specialist obstetricians in level 1 settings; 85% in level 2 settings and 86.8% in level 3 settings. (Table 36 below).

Table 36 Midwives Postnatal Liaison With the Medical Profession by Levels.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
General Practitioner	230	85.5	289	74.7	135	59.5
Specialist Obstetrician	144	53.5	329	85.0	197	86.8
Paediatrician	143	53.2	313	80.9	197	86.8
Anaesthetist	57	21.2	128	33.1	90	39.6
Other Medical Personnel	6	2.2	19	4.9	20	8.8

Table 37 Midwives Liaison With Other Health Professionals by Levels.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Physiotherapist	132	49.1	232	59.9	155	68.3
Social Worker	101	37.5	221	57.1	164	72.2
Dietitian	62	23.0	175	45.2	118	52.0
Pharmacist	76	28.3	185	47.8	128	56.4
Pathologist	69	25.7	164	42.4	102	44.9
Radiologist	32	11.9	117	30.2	67	29.5
Minister of Religion	49	18.2	115	29.7	105	46.3
Psychologist	34	12.6	66	17.1	64	28.2
Occupational Therapist	21	7.8	26	6.7	31	13.7
Other Health Professional	15	5.6	21	5.4	10	4.4

The frequencies of midwives nominating the health professionals they liaised with in the provision of postnatal care are shown in Table 37 above. Apart from one instance where occupational therapists were more frequently liaised with in level 1 (7.8%) than in level 2 settings (6.7%) there was an increasing liaison between midwives and other health professionals related to the increase in the level of service provided.

4.5.3.7 Utilisation of midwifery knowledge and skills in providing postnatal care

The majority of midwives practising postnatal care considered their knowledge and skills were, *utilised most of the time*, *well utilised*, or *fully utilised* (89.1% for knowledge utilisation and 87.3% for utilisation of skills). Tables 38 and 39 (p.126) indicate midwives perception of the levels of utilisation. Midwives working in levels 2 and 3 settings expressed higher estimates of the utilisation of their knowledge and skills than those midwives working in level 1 settings. Midwives in level 3 settings perceived their knowledge and skills to be more fully utilised (14.5% and 16.7%) than midwives in level 1 (6.7% and 7.1%) or level 2 (9.3% and 9.6%) settings. There were 10.9% of midwives practising postnatal care who considered their knowledge was poorly utilised while 12.7% considered their skills poorly utilised.

Table 38 Utilisation of Midwives' Postnatal Knowledge (by Hospital Levels).

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	3	1.1	1	0.3	2	0.9
Poorly utilised	37	13.8	28	7.2	11	4.8
Utilised most of time	94	34.9	139	35.9	72	31.7
Well utilised	115	42.8	178	46.0	105	46.3
Fully utilised	18	6.7	36	9.3	33	14.5

Table 39 Utilisation of Midwives' Postnatal Skills (by Hospital Levels).

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Not utilised	4	1.5	2	0.5	4	1.8
Poorly utilised	40	14.9	31	8.0	15	6.6
Utilised most of time	95	35.3	139	35.9	71	31.3
Well utilised	109	40.5	173	44.7	95	41.9
Fully utilised	19	7.1	37	9.6	38	16.7

4.5.3.8 Satisfaction with the division of responsibility within the health care team for postnatal care

Of the 795 midwives practising in postnatal care 93 (11.7%) said they had little or no satisfaction with the division of responsibility in the health care team providing intrapartum care. The majority (417 = 52.5%) said they were mostly satisfied; 228(28.7%) were well satisfied and 39 (4.9%) were highly satisfied. Table 40 (p. 127) provides details of satisfaction ratings for each of the levels of service.

Table 40 Satisfaction With Division of Responsibility for Postnatal Care.

	Level 1		Level 2		Level 3	
	f	%	f	%	f	%
Dissatisfied	1	0.4	2	0.5	5	2.2
Little satisfaction	38	14.1	39	10.1	16	7.0
Mostly satisfied	137	50.9	206	53.2	118	52.0
Well satisfied	79	29.4	110	28.4	71	31.3
Highly satisfied	9	3.3	22	5.7	12	5.3

Summary

This chapter has provided numerical data that demonstrates the actual tasks performed by the midwife in providing obstetric and neonatal care within the diverse practice settings throughout Australia. Midwives' responses to the questionnaire have indicated their perceived levels of autonomous decision making in performing identified tasks; involvement in determining policies and procedures that control practice; utilisation of midwifery knowledge and skills, and their levels of satisfaction with the division of responsibility within the maternity health care team.

These descriptive findings provide a data base of the segmented procedures undertaken by midwives in the provision of antenatal, intrapartum and postnatal maternity care. As the case study proceeds the process of integrating these procedural tasks with specialised midwifery competencies within models of maternity service provision in diverse practice settings is explored.

CHAPTER FIVE

FINDINGS - EVALUATIVE

5.1 Introduction

This chapter compares the descriptive findings of the previous chapter, which detailed the practice of Australian midwives in their diverse maternity settings, with the stated sphere of practice as defined in the *Standards for the Practice of Midwifery* (ACMI, 1989). These standards are based on the internationally accepted *Definition of a Midwife* (WHO, 1976).

This definition is described as *The International Confederation of Midwives' Definition (adopted 1972, amended 1990) accepted by the World Health Organisation and the International Federation of Gynaecology and Obstetrics ---(WHO 1976).* Following the *Definition of a Midwife,* and the *Sphere of Practice* (ACMI 1989: 4) the statement is made that:

> *This definition is recognised by all midwives as a good description of their role. Each country makes its own adaptions within and around this definition to fit varying lifestyles.*

The document *Standards for the Practice of Midwifery* (ACMI 1989) was developed *by midwives and non-midwives from all over Australia* and *is intended to be used by midwives in their diverse areas of practice* (p.3).

This Chapter evaluates midwives' ratings of their ability to practise within the internationally accepted *Definition of a Midwife* and the *Sphere of Practice* (WHO 1976), and their compliance with the *Standards for the Practice of Midwifery* (ACMI 1989).

It addresses the research question of:

What are the discrepancies between the Australian College of Midwives Incorporated (ACMI) Standards for the Practice of Midwifery (1989), including the stated definition of a midwife and the sphere of practice of a midwife (WHO, 1976), and the actual role demonstrated by empirical data?

Australian Midwives' acceptance of the World Health Organisation's *Definition of a Midwife (1976)* as an ideal has been assessed through responses to the survey

questionnaire and interviews with practising midwives. The extent to which midwives perceived themselves to be practising within the sphere of practice described in this definition has also been assessed.

5.2 Perceived acceptance of World Health Definition of a Midwife

Responses to the survey question of whether midwives considered the *World Health Definition of a Midwife* (WHO 1976) to be a good descriptor of the role of the Australian midwife, indicated that 847 (48.3%) considered it *an ideal to aim for but not currently practised fully by Australian midwives;* 386(22%) thought it *described current Australian midwives' practice;* 33 (1.9%) said it was *not a good descriptor;* 238 (13.5%) gave no opinion and 250 (14.5%) gave qualifying comments (Table 41 p.129).

Table 41 The World Health Organisation's (1976) Definition of a Midwife as a Descriptor of the Role of the Australian Midwife.

A GOOD DESCRIPTOR:	FREQUENCY	PERCENTAGE
As Currently Practised	386	22.0%
As An Ideal To Aim For	847	48.3%
No	33	1.9%
Qualifying Comments	250	14.5%
No Response	238	13.5%

Of the 250 qualifying comments 67 were expressions of lack of current knowledge to make an informed judgement; 23 were suggested changes that should be made to the definition; and 160 identified factors they considered inhibited Australian midwives from practising according to the WHO definition.

Content analysis of the 160 responses identifying 264 inhibiting factors is summarised in Table 42 (p.130). The 13 categorised factors are discussed and supported by qualitative data which is presented in Chapter Seven.

Table 42 Factors Identified as Inhibiting Midwives Fulfilling the WHO Definition of Their Role and Sphere of Practice.

INHIBITING FACTORS IDENTIFIED	NO. OF SPECIFIC COMMENTS
Medical Dominance	60
Lack of Opportunity to Practice in all Areas	47
The Effect of Practice Settings	37
Lack of Confidence	19
Regulations, Policies and Procedures	19
No Autonomy	17
Effects of Specialisation	13
Lack of Continuity	12
Lack of Community Recognition	10
Personal Factors	10
Differences Between U.K. and Australian Practice	9
Lack of Recognition by Nursing Profession	6
Economic Factors	5
TOTAL No. of SPECIFIC COMMENTS	**264**

5.3 Extent to which midwives perceived their own practice reflected in the sphere of practice defined by WHO

The majority of responding midwives perceived their practice to be similar to the sphere of practice described by the WHO definition. There were 449 (25.6%) who said there was some similarity; 534(30.4%) rated their practice as similar, and 324(18.5%) said that their practice was well reflected by the definition. There were 50(2.9%) who saw no similarity between their own practice and the definition, and 61(3.5%) who considered their practice fully reflected the definition.

Figure 7 (p.131) illustrates the percentage differences between groups. Midwives selected for interviews but who where not included in the random survey sample were more likely to perceive their practice as reflecting the WHO definition of the midwives' sphere of practice than those in the survey sample.

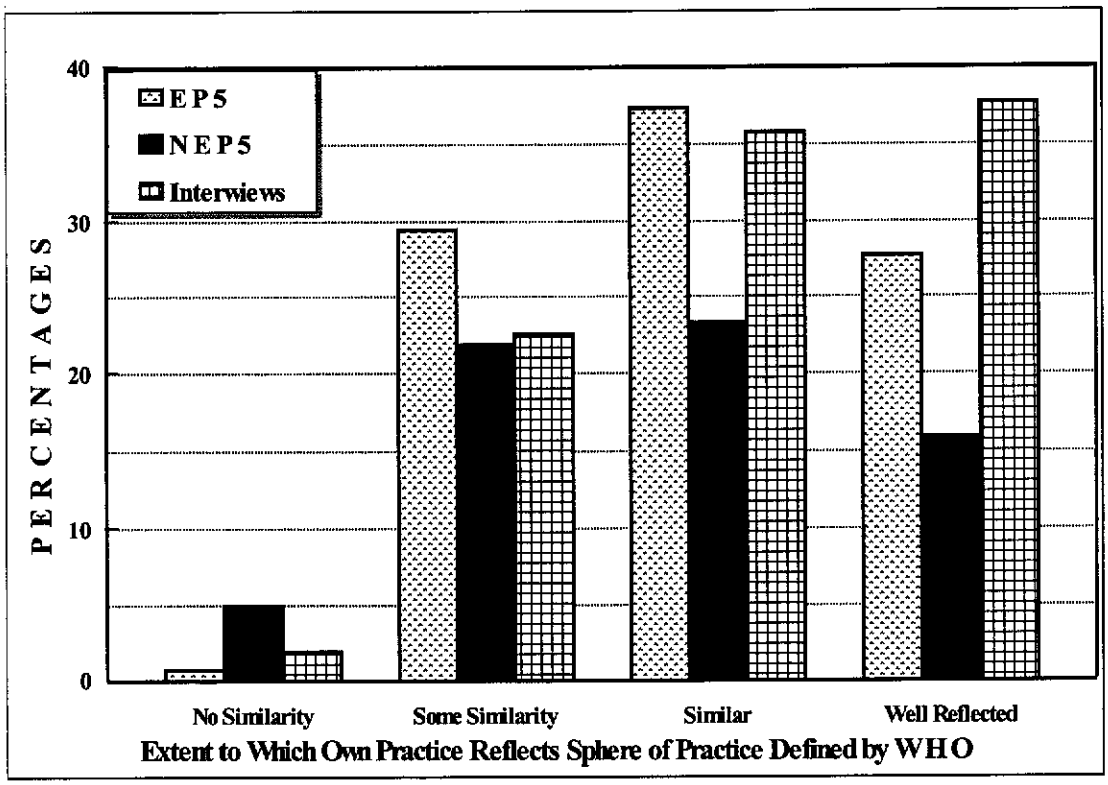


Figure 7: Extent To Which Midwives Perceived Their Own Practice Reflected The WHO Definition.

5.4 Components of the sphere of practice (WHO *Definition of a Midwife 1976).*

The components of the sphere of practice as described in *Standards for the Practice of Midwifery* have been used in this chapter as performance criteria with an evaluation of the extent to which Australian midwives perceived themselves practising within this description. The findings of each performance criterion are now presented.

5.4.1 Performance Criterion 1:

Gives the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period.

Evaluation:

Midwives participating in the survey questionnaire (n=1754) were asked to rate their satisfaction with the opportunities they had in their own practice to provide care throughout all stages of pregnancy and childbirth. Table 43 (p.132) provides details of the satisfaction ratings and the level of importance midwives placed on the availability

of these opportunities as requirements for midwives to be able to practise according to the WHO definition and sphere of practice. While 37.7% said they were *mostly satisfied* with opportunities in their own practice to provide care throughout all stages of pregnancy and childbirth, there were 26.7% who had *little or no satisfaction* , compared with 15% who were *well satisfied or highly satisfied.* Chapter Seven discusses the impact of practice opportunities on midwives within their diverse practice settings throughout Australia.

Table 43 Importance and Satisfaction Ratings with Opportunities to Provide Care at all Stages.

FACTOR	IMPORTANCE RATING	%	SATISFACTION IN OWN PRACTICE	%
Opportunity to Provide Care at **ALL** Stages	Missed Response	13.1%	Missed Response	20.6%
	Not Important	0.4%	Dissatisfied	4.2%
	Fairly Important	2.3%	Little Satisfaction	22.5%
	Important	23.4%	Mostly Satisfied	37.7%
	Essential	60.8%	Well Satisfied	11.6%
			Highly Satisfied	3.4%

Findings from the questionnaire demonstrated that midwives who had practised during the past five years had performed specific tasks in antenatal practice (Table 12 pp.81-82); intrapartum (Table 23 pp.93-100); and postnatal care (Table 34 pp.110-121). Of the 882 midwives who had practised during the past five years only 474 had provided antenatal, intrapartum and postnatal care inclusively. There were 133 who had not provided any antenatal care, 79 who had not provided intrapartum care and 14 had not practised in postnatal areas. A further 78 had not provided any perinatal clinical care. The lack of continuity of care throughout the three stages was illustrated in the answers to the open ended survey questions and the interviews with midwives. These findings are presented in Chapters Six and Seven.

5.4.2 Performance Criterion 2:

Conducts deliveries on her own responsibility.

Evaluation:

There were 473 midwives who had conducted deliveries during the past twelve months from the time the questionnaire was received. The total number of deliveries these midwives estimated they had performed during this time was 14231, an average of 30 deliveries per midwife.

Of the 660 midwives who indicated they had been involved in intrapartum care, 605 had conducted deliveries during the past five years. These midwives rated their most usual level of autonomous decision making when conducting a spontaneous vaginal delivery as *most usually performed following policies and procedures* (n=265=40.2%; and *practised independently i.e. autonomous decision making* (n=197=29.8%). There were 65(9.8%) who *assisted with procedure performed by a medical practitioner*; 20(3%) who *self performed under direct supervision of a medical practitioner present at the time*; and 58(8.8%) who *self performed under indirect supervision of a medical practitioner following his/her verbal or written orders* (Table 44 p.133).

Table 44 Most Usual Level of Autonomous Decision Making by Australian Midwives when Conducting a Spontaneous Vaginal Delivery

LEVEL OF AUTONOMY	FREQUENCY	PERCENT
Performed following policies and procedures	265	40.2%
Practised independently (autonomous decision making)	197	29.8%
Assisted medical practitioner	65	9.8%
Indirectly supervised by medical practitioner (followed verbal or written orders)	58	8.8%
Directly supervised by medical practitioner	20	3.0%

5.4.3 Performance Criterion 3:

Cares for the newborn and the infant.

Evaluation:

There were 795 midwives of the 882 midwives who had been employed during the past 5 years, who had provided postnatal care. Of these 86% (684) had provided care to the newborn infant during the first hour of life while 93% (743) had cared for the infant during the first three days of life. There was a marked decrease in the number of midwives who had provided care following the first few days. During the first 10 days of life 72.5% of midwives providing postnatal care had not been involved in domiciliary care of the infant while 88% of midwives had not provided ongoing care to infants up to the first year of life. This percentage was the same for care of infants up to 5 years.

5.4.4 Performance Criterion 4:

Provides preventative measures.

Evaluation:

The provision of preventative measures is included in the WHO definition of the *Sphere of Practice,* as care that should be provided throughout *pregnancy, labour and the postpartum period ... and care for the newborn and infant.*

Preventative measures in the context of the WHO definition of the sphere of practice of the midwife refer to active measures taken to prevent adverse outcomes for the childbearing women and their families.

During the provision of antenatal care midwives did not indicate active preventative measures other than those directly related to health counselling and antenatal education. This lack of emphasis on preventative measures during antenatal care reflects the paucity of opportunities for midwives to be involved in the care of women with normal pregnancies. As stated earlier (p.76) the majority of antenatal care provided by midwives was to hospital inpatients. Preventative measures practised at this stage were in the care of high risk women requiring monitoring to detect early signs of abnormal conditions and prevent complications through early treatment.

Preventative measures in the provision of care during labour included the provision of comfort measures, demonstration of breathing and relaxation methods, identification and attention to hygiene, safety, social interaction and support needs,

knowledge, nutritional, oxygenation, and elimination needs. These needs were attended to by 95% of the midwives who said they had been involved in providing intrapartum care.

The administration of prophylactic oxytocics to prevent postpartum haemorrhage had been performed by 91.7% of midwives providing intrapartum care. A preventative measure not so well attended to during the provision of intrapartum care was the development of a client/family orientated birthing care plan. Only 121 (18.3%) midwives said they had developed a birthing care plan during the past five years.

During the postpartum period much of the care given by midwives to mothers and their babies was preventative. Through the provision of a safe environment, monitoring normal postpartum physiological processes, maintaining comfort, hygiene, nutritional and elimination needs, encouraging bonding and facilitating breast feeding, adverse outcomes for the mother and infant were prevented. These preventative measures were provided by 91% of midwives who had been involved in postnatal care during the past five years.

Preventative measures taken in the care of the newborn included maintenance of a thermoneutral environment, maintenance of a clear airway, maintenance of a safe environment, prevention of infection, administration of Vitamin K, promotion of attachment and acceptance and facilitation of parent infant interaction. There were 93.4% of midwives providing care to the newborn who responded as providing these preventative measures.

Provision of preventative measures for the infant in the domiciliary and community settings included provision of illness prevention measures, administering immunisation, monitoring development of the infant and promoting family focused health. There were 58.9% of midwives providing postnatal care who had not been involved in domiciliary infant care, and 77.8% who had not provided preventative measures for infants during the first years of life.

5.4.5 Performance Criterion 5:

Detects abnormal conditions in mother and child.

Evaluation:

Midwives providing *care during pregnancy, labour and the postpartum period ... and care for the newborn and infant* were active in assessing and monitoring for the detection of abnormal conditions at all stages of pregnancy and childbirth.

Of the 606 midwives involved in antenatal care 79.5% had identified factors requiring referral to other health professionals. Procedures performed to detect abnormal conditions included: obtaining and documenting an obstetrical history (90%); conducting an initial maternal assessment (70.5%); abdominal assessment, palpation and auscultation (89.3%); vital signs assessment (90%); cardiotocograph interpretation (79%); fetal heart monitoring with pinards stethoscope or doppler (92%); urinalysis (92%); venipuncture (70%); and ordering and collecting specimens for laboratory testing (35%).

In the intrapartum period the monitoring and assessment procedures continued. Table 23 (p.93) indicates the level of autonomy at which midwives considered they practised these assessment and monitoring procedures. During the first stage of labour midwives continuously assessed the labouring status of the woman together with the well-being of the fetus (95% of midwives involved in intrapartum care). There were 92% of midwives involved in intrapartum care who said they identified complications.

Detection of complications through continuing assessment and monitoring procedures was demonstrated in the postnatal period. While providing immediate postpartum care 88.1% of the 795 midwives involved in postnatal care had identified postpartum haemorrhage; 91% had detected infection; 90% excessive breast engorgement; 94% cracked nipples; 86% had detected disease processes; 92.5% emotional instability and 91.4% psycho/social problems (Table 34 p.113).

During the first three days of infant care 92.6% of midwives providing postnatal care had detected abnormalities; 89% hypoglycaemia; 94% had identified feeding problems; 94% had identified excessive bilirubin levels, and 79% had detected gastro intestinal malfunction (Table 34 p.117).

5.4.6 Performance Criterion 6:

Procures medical assistance.

Evaluation:

When asked to indicate the most usual level of autonomy at which specific tasks were performed the responses from midwives indicated that some tasks were more usually performed by a medical practitioner with assistance being given by the midwives. These

procedures were related to the treatment of abnormal conditions detected by the midwives through assessment and monitoring during pregnancy, labour and the postnatal period.

Care of the high risk client during the antenatal stage was rated as being *self performed under the indirect supervision of a medical practitioner following his/her written orders.* The ultrasound procedure was also rated as being most usually performed as *assisted with procedure performed by medical practitioner.*

During the intrapartum period midwives assisted a medical practitioner for the procedure of electronic fetal heart monitoring using fetal scalp electrodes. Obtaining and testing a fetal scalp sample for pH testing was another procedure where midwives assisted the medical practitioner.

Midwives also assisted medical practitioners during the procedures of augmentation and induction of labour. These interventions may or may not have been the result of midwives seeking medical help. Medical intervention is discussed in Chapters Six and Seven where the qualitative data, from open ended questionnaire responses and midwives interviews, are presented.

Where spontaneous vaginal delivery did not occur midwives assisted medical practitioners with procedures such as vacuum extractions (45.5% of midwives providing intrapartum care); non rotational forceps delivery (56.7% of midwives assisted medical practitioners); rotational instrumental delivery (55.8%), and assisting at Caesarean Section (51.4% of midwives providing intrapartum care). (Table 23 p.98).

Where complications arose during the third stage of labour midwives procured medical assistance. Procedures rated as being most usually performed by assisting a medical practitioner included: manual removal of retained placenta (51.7% of midwives had assisted the medical practitioner, while 42.6% had not been involved in the procedure during the past 5 years); emergency treatment following inversion of the uterus (19.7% had assisted a medical practitioner while 73.7% had not been involved in this procedure); and suturing of perineal trauma was most usually performed by assisting the medical practitioner, while 38.1% said they had not performed the procedure during the past 5 years. (Table 23 p. 100).

5.4.7 Performance Criterion 7:

Executes emergency measures.

Evaluation:

Emergency measures executed by midwives included: the treatment of haemorrhage (62% of midwives had *self performed following policies and procedures,* or *practised independently i.e. autonomous decision making);* provision of cardio-pulmonary resuscitation to the infant (36.6%); initiation of intravenous therapy (31%); administration of oxygen to mother or infant (87.2%), and preparation of women for emergency surgical intervention (73.5%). (Table 23 p.100 and Table 34 p.115).

5.4.8 Performance Criterion 8:

Provides health counselling and education for mothers, their families and their communities.

Evaluation:

There were 81% of midwives involved in antenatal care (n=606) who had provided antenatal care counselling. Preconceptual care counselling had not been given by 72.6% of these midwives. In response to the question of whether families of the childbearing women had been included in their antenatal care there were 64.5% (391) affirmative and 32.5% (197) negative responses.

Health counselling and education for mothers and their support persons during the intrapartum period took the form of information giving about physiological changes occurring during labour and providing support and guidance. This was performed by 94% of the 660 midwives involved in providing intrapartum care.

The postnatal period was a time of intensive education for the mothers preparing to care for their new infants. Mothers were educated and assisted in postnatal self care, breast-feeding and infant care. Information was also provided on community support services. There were 94% of midwives who said they provided education in these areas for mothers while 80.6% said they included families in postnatal care.

Midwives providing domiciliary postnatal care and midwives in Child Health Services were involved in promoting family focused health (Table 34 p.120).

5.4.9 Performance Criterion 9:

Provides antenatal education and preparation for parenthood.

Evaluation:

There were 489 (80.7%) midwives involved in antenatal services whose clinical care included individual client teaching. Of the 606 midwives providing antenatal care 391 (64.5%) included the families of the childbearing women in the care they provided. Antenatal parent education for client groups was given by 314 (51.8%) of midwives in antenatal practice.

5.4.10 Performance Criterion 10:

Counsels and provides education in certain areas of gynaecology, family planning and child care.

Evaluation:

Parent education in infant care was practised by 747 (94%) of midwives as part of postnatal care. The giving of information regarding support services was practised by 93% of these midwives.

There were 12% of midwives providing postnatal care who said they had conducted child health clinics for infants. Some midwives indicated that they were child health nurses and had not completed the other sections of the questionnaire that related to antenatal, intrapartum and postnatal practice.

Advice on contraception had not been given by 448 (56.3%) of the postnatal midwives, and 585 (73.6%) had not assisted in family planning. The survey findings did not indicate that midwives were involved in providing education and counselling in gynaecology although this may have been included in their references to other nursing employment.

5.4.11 Performance Criterion 11:

Practises in hospitals, clinics, health units, domiciliary conditions or any other service.

Evaluation:

Practice settings during the provision of antenatal, intrapartum and postnatal care have been detailed in Chapter 3. Table 11 (p.79) shows that 83.3% of the 606 midwives

involved in antenatal care had practised in hospitals; 45.9% in a hospital outpatient clinic; 12.9% in domiciliary settings; 6.8% in Women's Health Centres; 5.3% in Family Planning Clinics; 2% in medical practitioners' surgeries, and 9.7% nominated *other.*

Table 19 (p. 90) indicates the intrapartum practice settings for 660 midwives. There were 74.1% who nominated specialist obstetrician hospital care and 70% general practitioner hospital care. These figures demonstrated that midwives were often working with specialist obstetricians and general practitioners together. There were 17.4% of midwives who said that they had practised in alternative birthing suites; 12.7% in birth centres; 5.6% in domicilliary settings, and 3.9% indicated *other.*

Table 30 (p.107) again combines specialist obstetrician and general practitioner practice settings with 73.8% and 62.5% respectively. Other postnatal settings included; birth centres 9.9%; alternative birthing suite 11.1%; domicilliary setting 10.3%; and *other* 8.2%.

5.5 Midwives' perceptions of the adequacy of their knowledge and skills to fulfill the World Health Definition of a Midwife.

The majority of midwives responding to the questionnaire survey (n=1754) considered their knowledge and skills to be adequate in most, or all areas. There were 462 (26.3%) who felt their skills inadequate in some areas; 199(11.3%) said they had inadequate skills; 160(9.1%) responded as *not applicable*, and there were 52 missed responses to the question. Those who did not respond to the questionnaire wrote additional comments stating they had not practised for over five years and had lost their skills.

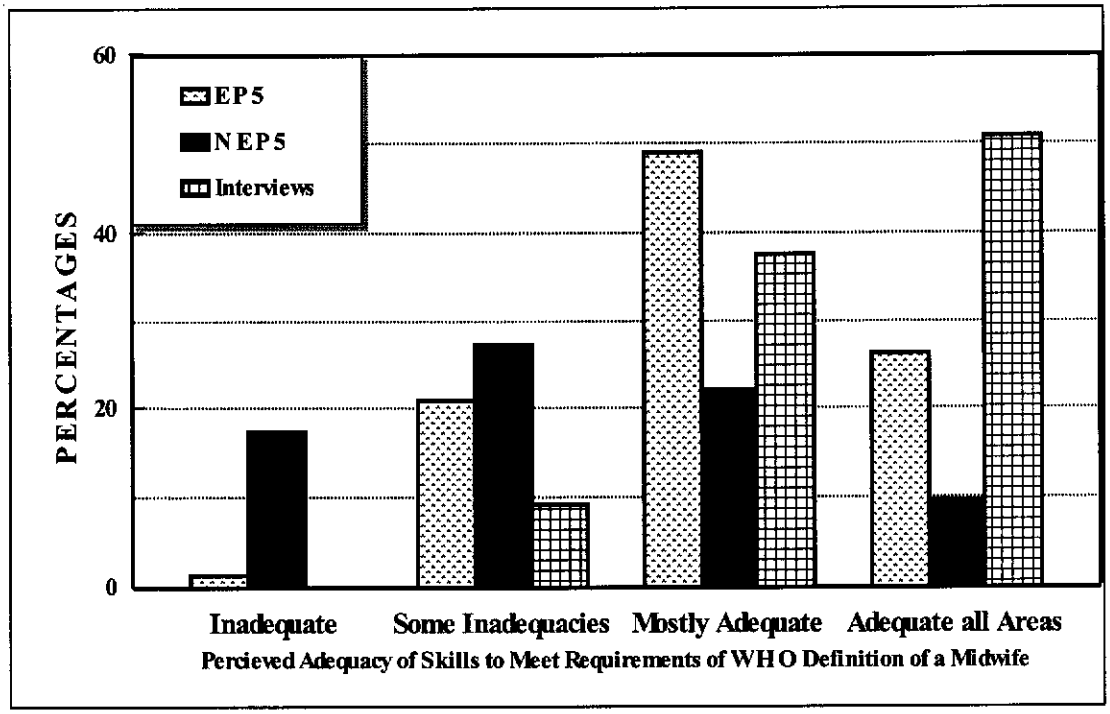


Figure 8: Perceived Adequacy Of Skills To Meet Requirements Of WHO Definition Of A Midwife

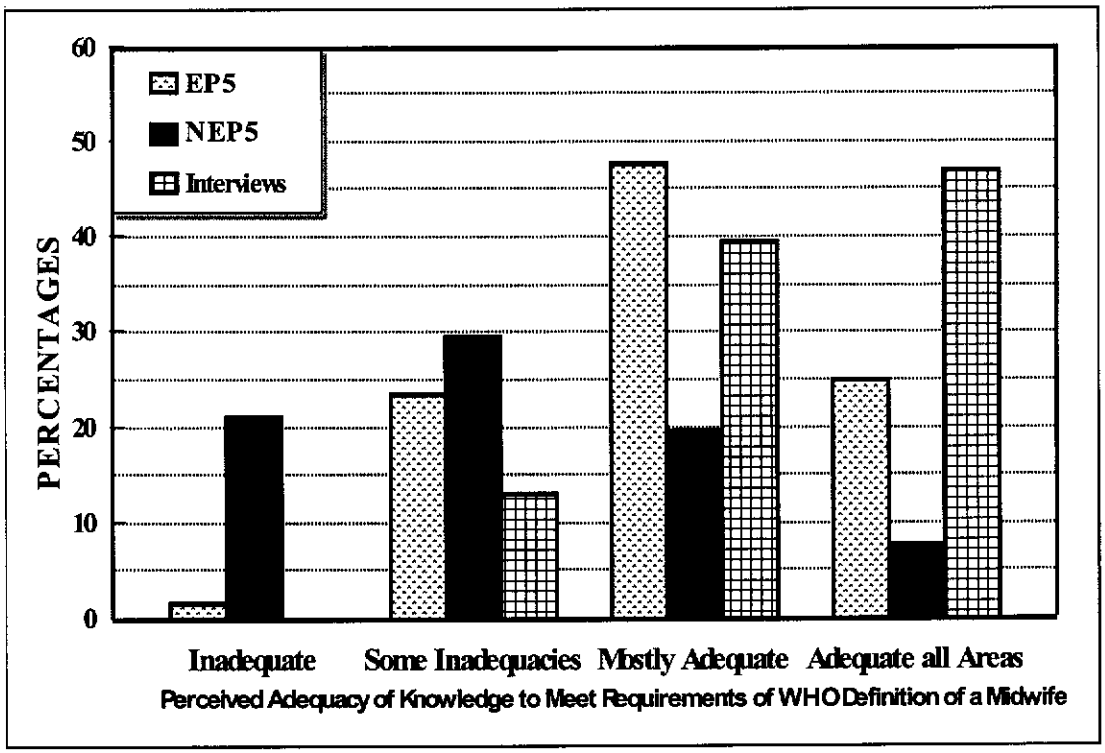


Figure 9: Perceived Adequacy Of Knowledge To Meet Requirements Of WHO Definition Of A Midwife

Figure 8 (p.141) shows the difference in the levels of expressed adequacy of skills between midwives who had not practised for the past five years, currently practising midwives, and the group of midwives selected for interviews.

There was a slight but observable difference between midwives' perceptions of their knowledge compared with their skills. Again the majority 630 (35.9%) thought their knowledge was adequate in most areas; 274 (15.6%) felt they were adequate in all areas, and 44 (2.5%) felt their knowledge was more than adequate to fulfill the WHO definition. There were 422 (24.1%) who said their knowledge was inadequate in some areas; 163 (9.3%) felt their knowledge was inadequate, while 164 replied that it was not applicable and 57 missed the question. Written comments indicated that these midwives were no longer practising. Figure 9 (p.141) illustrates the differences in perceptions of adequacy of knowledge given by those midwives who had not practised during the past 5 years, midwives currently practising, and those midwives selected for interviews.

5.6 Midwives ratings of the utilisation of their knowledge and skills during their years of employment.

There were 79.3 % of the midwives selected for interviews who considered their midwifery skills to be well utilised. This compares with 61.7 % of practising midwives (EP5) and 43.4 % of non practising midwives (NEP5). (Table 45 p.143).

Ratings given for the utilisation of midwifery knowledge throughout their years of practice followed the same pattern with 90.5 % of the selected midwives (Interview group) stating their knowledge was well utilised; 68.9% of practising midwives (EP5) and 47.5% of non practising midwives (NEP5) rating their knowledge as well utilised. (Table 46 p.143).

Table 45 Utilisation of Midwifery Skills

	Missed Or Not Applicable	Not Utilised	Poorly Utilised	Utilised Most of Time	Well Utilised
Practising Midwives	1.0%	0.3%	9.3%	27.7%	61.7%
Selected Midwives	1.9%	0.0%	3.8%	15.1%	79.3%
Non Practising Midwives	18.4%	6.3%	10.1%	21.9%	43.4%

Table 46 Utilisation of Midwifery Knowledge.

	Missed Or Not Applicable	Not Utilised	Poorly Utilised	Utilised Most of Time	Well Utilised
Practising Midwives	0.7%	0.1%	6.0%	24.4%	68.9%
Selected Midwives	0.0%	0.0%	0.0%	9.4%	90.5%
Non Practising Midwives	18.1%	5.3%	8.7%	20.5%	47.5%

5.7 Midwives knowledge of the Australian College of Midwives Incorporated *Standards for the Practice of Midwifery (ACMI 1989).*

There were 1069 (60.9%) midwives from the randomly selected survey sample (n=1754) who said they had not read the *Standards for the Practice of Midwifery* (1989). Table 47 (p.144) provides a comparison between the practising midwives (n=882), non practising (n=864), and the midwives selected for interviews (n=53). Of the interviewed group, 81.1% had read the *Standards*, as had 51.4% of the practising midwives and 16.2% of those midwives who had not practised during the past five years.

These low percentages of midwives who had read the *Standards for the Practice of Midwifery* (ACMI 1989) can be compared with the number of midwives who had membership with the *Australian College of Midwives* (13.6%).

Table 47 Read the ACMI Standards for the Practice of Midwifery.

	YES		NO		MISSED
	f	%	f	%	%
Practising Midwives	453	51.4%	409	46.4%	2.3%
Non practising Midwives	140	16.2%	657	76.0%	7.7%
Select Group of Midwives	43	81.1%	10	18.9%	0.0%

5.8 Components of the *Standards for the Practice of Midwifery (ACMI 1989).*

The *Standards for the Practice of Midwifery* (1989) define four standards each with midwifery process and outcome behaviours as performance criteria. These four standards address the areas of professional responsibility and accountability, midwifery practice, health education and legislation, and policies and procedures.

Compliance ratings with *Standards for the Practice of Midwifery (ACMI 1989).*

5.8.1 Standard 1 Professional Responsibility and Accountability

The midwife achieves responsibility and accountability for her own practice through self-evaluation, takes responsibility for personal professional development and facilitates the education of colleagues and students. (ACMI, 1989: 4).

5.8.1.1 Performance Criterion 1:

Achieves responsibility and accountability for her own practice through self-evaluation.

Evaluation:

Midwives participating in the survey questionnaire who had been employed as midwives during the past five years (n=882) were asked how often their standard of practice had been evaluated against professional standards during the past five years, and whether this evaluation had involved self evaluation and/or peer review.

The majority (479=54.3%) stated their performance had been evaluated through self and peer appraisal. There were a further 54 (6.1%) who said they evaluated and documented a self appraisal each year; 172 (19.5%) had not evaluated their performance during the five years, and 121 (13.7%) had officially appraised their performance more than once in the past five years but not annually, (Table 48 p.145).

Table 48 Midwives Individual Evaluation of Practice Against Professional Standards by Midwives Employed During the Past Five Years

n=882

	f	%
annual appraisal (by self and peers)	479	54.3%
no official appraisal	172	19.5%
annual self evaluation (documented)	54	6.1%
official appraisal more the once in five years but not annually	121	13.7%

There were 48 (5.4%) "*not applicable*" responses, and 8 (0.9%) "*missed*".

When asked for their views on performance appraisal in relation to their own practice and experience there were more positive (1016) than negative opinions (338) expressed. Table 49 (p.146) provides the frequencies and percentages of these comments.

Table 49 Midwives Views of Performance Appraisal in Relation to Personal Experience by Midwives Employed During the Past Five Years

n=882

	f	%
good opportunity for feedback from peers	411	46.6%
motivating objective setting process	216	24.5%
reflective evaluation of performance	389	44.1%
time wasting	98	11.1%
controlling mechanism of hierarchy	121	13.7%
pressure to increase performance	95	10.8%
unnecessary for professionals	24	2.7%

There were 51 (5.8%) "*not applicable*" responses, and 8 (0.9%) "*missed*".

5.8.1.2 Performance Criterion 2:

Takes responsibility for personal professional development.

Evaluation:

Midwives were asked which activities they had participated in during the past twelve months to maintain their midwifery knowledge. Table 50 (p.147) shows the percentages within the three groups (non practising midwives, practising midwives and midwives selected for interviews). The responses indicate that the majority of non practising midwives did not participate in activities to maintain or develop their midwifery knowledge. There was also a marked difference between the frequencies of participation in professional development activities undertaken by the random sample of currently practising midwives and those midwives who had been selected for interview. The selected interviewees had a higher percentage for all activities than the randomly selected sample of practising midwives.

Attending clinical workshops and seminars ranked highest amongst professional development activities. There were 90.6% of the selected interviewees who had participated during the past 12 months, and 65.6% of the practising midwives. Regular reading of current midwifery journals also received a high percentage from these two

groups (88.7% and 61.7%), and was the most frequently stated professional development activity nominated by non practising midwives.

Other professional development activities that midwives engaged in to maintain or develop professional knowledge included: studying current midwifery books (44.6% of survey sample of practising midwives); attending midwives professional meetings (30%); clinical reviews (19.8%), and diverse practice opportunities (16.9%).

Demographic data included in Chapter Four shows the number of midwives who had completed tertiary courses (fig. 5 and fig. 6 p.72).

Table 50 Methods Used by Midwives to Maintain Knowledge.

Method	Non Practising Midwives	Practising Midwives	Selected Group Midwives
Regular reading of current midwifery journals	15.5 %	61.7 %	88.7 %
Studying current midwifery text	8.3 %	44.6 %	60.4 %
Attending midwives professional meetings	3.8 %	30.0 %	77.4 %
Attending clinical seminars and workshops	9.1 %	65.6 %	90.6 %
Clinical review	1.7 %	19.8 %	47.2 %
Diverse practice opportunities	3.4 %	16.9 %	34.0 %
Other	6.7 %	7.9 %	17.0 %

5.8.1.3 Performance Criterion 3:

Facilitates the education of colleagues and students.

Evaluation:

The 882 midwives, from the randomly selected sample (n=1754), who had practised during the past five years were questioned on five aspects of facilitating the education of colleagues and students. As the majority of these midwives indicated they had not participated in these activities during the past twelve months, the percentage responses are given in the negative.

There were 533 (60.4%) practising midwives who said they had not participated in the orientation of other midwives to a practice setting; 569 (64.5%) had not preceptored student midwives; 722 (81.9%) had not given clinical care group presentations to their colleagues; 686 (77.8%) had not demonstrated advanced clinical skills to other midwives or students, and 704 (79.8%) had not presented midwifery practices at a seminar, (Table 51 p.149).

In comparison, the group of interviewee midwives selected through purposive sampling, indicated greater involvement in their responses to the same questionnaire. Of the 53 interviewees 73.6% had been involved, during the past twelve months, in orientation; 50.9% in preceptoring student midwives; 34% had given clinical care group presentations to colleagues; 43.3% had demonstrated advanced clinical skills, and 47.2% had participated in midwifery practice seminars.

Table 51 Participation in Professional Development Activities During the Past Twelve Months by Midwives Employed During the Past Five Years

n=882

	YES		NO	
	f	%	f	%
orientation of midwives	291	33.0%	533	60.4%
preceptoring student midwives and/or "refresher" midwives	255	28.9%	569	64.5%
clinical care group presentation to midwifery colleagues	102	11.6%	722	81.9%
demonstration of advanced midwifery skills	138	15.6%	686	77.8%
midwifery practice seminar presentation	120	13.6%	704	79.8%

There were 51 (5.8%) "*not applicable*" responses, and 7 (0.8%) *"missed"*.

There were midwives who nominated the education of midwives as part of their practice in specific areas. Of the 606 midwives who had been involved in antenatal services during the past five years 137 (22.6%) had provided education for midwives; 153 (23.2% of 660) intrapartum education; and 207 (26% of 795) postnatal education for midwives. There was a higher percentage of educational involvement in all areas amongst the selected interview group. Of these 53 selected midwives 37.7% had been involved in educating midwives in antenatal practices; 43.3% in intrapartum practices and 52.8% in postnatal practices.

5.8.2 Standard 2 Midwifery Practice

The midwife utilises a problem solving approach in order to provide comprehensive midwifery care to individuals, families and communities.

There are 10 midwifery process behaviours listed in the *Standards for the Practice of Midwifery* (ACMI 1989, Appendix 9). These will be addressed as they relate specifically to the actual practice of Australian midwives and provide the yard stick by which differences between the actual practice and the accepted standards of practice can be measured. While the *ACMI Standards* provide both process and outcome criteria for each standard only process criteria are addressed in this section. This

decision was based on the assumption that midwives' responses to the questionnaire could be expected to reflect the actions midwives perform but they could not adequately reflect the outcomes of behaviours. These are more appropriately evaluated through direct observation. Chapter Seven, *Findings - Qualitative* discusses the consequences of midwifery behaviours within their contextual settings.

Midwifery Practice Process Behaviours

5.8.2.1 Performance Criterion 1:

The midwife maintains knowledge of current developments and trends in midwifery practice.

Evaluation:

Midwives were asked what activities they had participated in during the past twelve months to maintain their professional knowledge at current levels. The responses of the randomly selected survey sample (n=1754) are presented in Table 50 (p.147). They have been divided into currently practising midwives (EP5 n=882) and midwives who had not practised during the past 5 years (NEP5 n=864). The responses of these two groups are also compared with those of the 53 purposely selected midwives for interviews who completed the same questionnaire as the survey participants. A much greater percentage of the purposely selected midwives and currently practising midwives, participated in all activities, than those midwives who had not practised during the past five years. Although the low level of participation amongst non practising midwives could be expected, the difference between the purposely selected interviewees and the randomly selected practising midwives indicates a wide range in the midwives' compliance with this process behaviour criterion.

Methods used by currently practising midwives (n=882) to maintain knowledge of current developments and trends in midwifery practice included: regular reading of current professional midwifery/obstetric journals, 61.7%; studying current midwifery/obstetric books and texts, 44.6%; attending midwives' professional meetings, 30%; attending clinical lectures, seminars or workshops, 65.5%; participating in clinical reviews, 19.8%; participating in diverse practice opportunities, 16.9%; and *other methods* 7.9%.

5.8.2.2 Performance Criterion 2:

The midwife applies a problem solving process to all aspects of midwifery care.

Evaluation:

In response to the question of whether they had used a problem solving approach in providing perinatal care over half (456=51.7%) of the midwives who had practised during the past five years (n=882) did not indicate they had done so. There were 41.6% (367) who said they had used a problem solving approach, and 59 (6.7%) who did not respond to the question.

5.8.2.3 Performance Criterion 3:

The midwife identifies the health needs/problems of the childbearing family in a consultative process with the families involved.

Evaluation:

Midwives were asked if they had participated in setting family orientated goals with input from the consumer (childbearing families). Responses from the 882 currently practising midwives indicated there were only 24% who had done so.

In answer to the question of whether midwives involved in providing antenatal care (n=606) had developed a family orientated pregnancy care plan there were 251 (41.4%) who had not done so during the past five years. Midwives involved in providing intrapartum care (n=660) indicated that 81.6% had developed a client/family orientated birthing care plan. Responses from the 795 midwives providing postnatal care indicated that 91.3% assessed family processes and informational needs while 80.6% said they included the families of the childbearing women in their postnatal care. During the postnatal period midwives also indicated they encouraged family bonding attachment processes.

These findings suggest that although midwives perceived themselves as involving families in perinatal care this did not usually include family consultation in setting family orientated goals to address identified health needs and problems during pregnancy.

5.8.2.4 Performance Criterion 4:

The midwife refers to other members of the health care team when problems arise which are outside the scope of midwifery practice.

Evaluation:

Midwives liaised with other members of the health care team throughout the provision of perinatal care. The descriptive findings presented in Chapter 4 Tables 15 (p.87), 26 (p.104), and 37 (p.125), provide frequencies of midwives liaison with other health professionals during antenatal, intrapartum and postnatal provision of care. While midwives stated they liaised with a large team of health professionals there was no indication given that midwives considered the consultative care approach was only taken when problems arose outside the scope of midwifery practice, rather liaison with other health professionals was an integral part of midwifery practice.

During the antenatal period 78.2% of the 606 midwives involved in providing antenatal care said they had identified factors requiring referral to other health professionals; 82.7% of the 660 midwives involved in intrapartum care had identified complications requiring referral to medical practitioners, and 83.2% had made referrals to a paediatrician during the provision of care to the newborn.

Procedures that were rated as being most usually performed by midwives at the level of *assisted with procedure performed by medical practitioner* or *procedure not practised during the past five years* included: ultrasound, electronic fetal heart monitoring using fetal scalp electrodes, obtaining and testing fetal scalp sample for pH testing, assessment of cervix for induction, artificial rupture of membranes, insertion of intravenous cannula, administration of anaesthetic/analgesic drugs via the epidural route, vacuum and forceps deliveries, assisting at Caesarean section, manual removal of retained placenta, emergency treatment following inversion of the uterus, suturing of perineal trauma, initiation of intravenous therapy, preparation for transfer to intensive care, monitoring arterial blood gases, and ordering and reviewing x-rays (Table 52 p.153). Actual percentages of the level of autonomous practice midwives perceived themselves to have in performing specific procedures are provided in (Table 12 pp. 81-83; Table 23 pp. 93-96; and Table 34 pp.110-121).

Table 52 Procedures Most Likely to be Performed at the Level of Assisting the Medical Practitioner

Procedure	Assist MP		Self Perform		Not in 5yrs	
	f	%	f	%	f	%
Ultrasound	102	16.8	35	5.8	469	77.3
Fetal Scalp Electrodes Monitoring	167	25.3	276	35.5	218	33.1
Obtaining Fetal Scalp Sample for pH Testing	149	22.6	36	5.4	475	71.9
Assessment of Cervix for Induction	254	38.5	202	30.6	204	31.0
Artificial Rupture of Membranes	230	34.8	270	40.9	160	24.3
Insertion of Intravenous Cannula	267	40.5	105	16.0	288	43.6
Initiation of Intravenous Therapy	313	39.4	265	36.4	217	27.3
Epidural Administration of Anaesthetic/Analgesic	247	37.4	216	32.8	197	29.8
Vacuum Deliveries	300	45.5	14	2.1	346	52.5
Forceps Deliveries	374	56.7	14	2.1	272	41.2
Assist at Caesarean	339	51.4	98	14.7	223	33.8
Removal of Retained Placenta	341	51.7	38	5.8	281	42.6
Suturing of Perineal Trauma	332	50.3	93	14.0	251	38.1
Ordering and Reviewing X-Rays	277	34.8	128	16.1	390	49.0
Monitoring Arterial Blood Gases	217	27.3	176	22.1	402	50.6

5.8.2.5 Performance Criterion 5:

The midwife maintains comprehensive documentation of all midwifery care.

Evaluation:

There were 555 (62.9% of 882 currently practising midwives) who indicated they met legal requirements for documentation. The purposely selected group of midwives rated higher at 79.2%.

Participation in continuous quality improvement to customer services through evaluation of outcomes for the childbearing women and their families was only indicated by 229 (26%) of the currently practising midwives. Again, there was a higher rating from the selected group (62.3%), (Table 53 p.155).

5.8.2.6 Performance Criterion 6:

The midwife recognises specific neonatal needs/problems.

Evaluation:

The specific procedures involved in the recognition of the needs of the neonate are listed in Table 34 (pp.117-119). Midwives involved in the immediate care of the newborn and care during the first few days of life indicated that over 90% recognised the needs of the neonate and practised procedures to meet specific needs. These procedures included: maintenance of thermoneutral environment (93.4%); maintenance of a clear airway (91.6%); assessment of respiratory rate and effort (89.8%); monitoring and assessment for disease processes (89.7%); maintaining fluid balance (91%), and identification of feeding problems (94.1%). Other neonatal specific procedures are included in Table 34 (pp. 117-119).

5.8.2.7 Performance Criterion 7:

The midwife promotes a safe environment for the childbearing family.

Evaluation:

The 882 midwives who had practised during the past five years were asked if they promoted safe environmental standards as part of continuous quality improvement to customer services. There were 458 (51.9%) who indicated they had promoted safe environmental standards; 365 (41.4%) did not indicate that they had done so, and there were 59 missed responses.

In response to the question of whether they reported accidents and incidents that occurred 503 (57%) indicated they had participated, while 36.3% had not participated.

Table 53 Participation in Continuous Quality Improvement to Customer Services by Midwives Employed during the Past Five Years

	YES		NO	
	f	%	f	%
setting family oriented goals with input from the consumer	212	24.0%	611	69.3%
using a problem solving approach in providing perinatal care	367	41.6%	456	51.7%
promoting safe environmental standards	458	51.9%	365	41.4%
reporting accidents and incidents	503	57.0%	320	36.3%
meeting legal requirements for documentation	555	62.9%	268	30.4%
acting as the consumers advocate	339	38.4	484	54.9%
participating in clinical care reviews with other health professionals	298	33.8%	525	59.5%
evaluation of consumer outcomes	229	26.0%	594	67.3%
providing input to policies and procedures guiding consumer focused services	369	41.8%	454	51.5%
other	17	1.9%	806	91.4%

There were 51 (5.8%) "*not applicable*" responses, and 8 (0.9%) "*missed*".

5.8.2.8 Performance Criterion 8:

The midwife promotes family relationships.

Evaluation:

Of the 606 midwives who had been involved in providing antenatal care there were 314 (51.8%) who had provided parent education for client groups. In response to the question of whether their antenatal care had included the families of the childbearing women 391 (64.5%) gave an affirmative reply. Individual client teaching while providing clinical antenatal care was given by 489 (80.7%) of these midwives.

During the intrapartum period 566 (85.8% of 660) midwives said that the intrapartum care they provided included the families of the childbearing women. There were 376 (57%) who said their care included intrapartum education.

In addition to postnatal education, provided by 605 (76.1%) of midwives, the families were included in the postnatal care of the childbearing women (641 = 80.6%). During this time there was a more active approach towards promoting family relationships. There were 726 (91.3%) of these midwives who *assessed family processes and informational needs,* and 741 (93.2%) who *encouraged family bonding attachment processes.*

5.8.2.9 Performance Criterion 9:

The midwife recognises emotional crisis in the childbearing family.

Evaluation:

During the antenatal period there were 490 (80.8% of 606) midwives who had provided counselling. Midwives indicated that they liaised with other health professionals in providing emotional support to the childbearing women and their families. There were 292 (48.2%) who had referred to social workers; 130 (21.5%) liaised with ministers of religion, and 77 (12.7%) referred to psychologists.

The recognition of emotional crisis was an integral part of intrapartum care. Of the 660 midwives involved in providing intrapartum care 629 (95.3%) said they made an initial and continuing assessment of the emotional status of the client. There were 619 (93.8%) who provided information and support, and emotionally prepared the client and family for invasive procedures during the intrapartum period.

The identification and treatment of emotional instability during the postpartum period had been practised by 736 (92.6% of 795 midwives providing postnatal care). There were 666 (83.7%) of these midwives who had supported parents and families affected by infant morbidity and/or mortality.

5.8.2.10 Performance Criterion 10:

The midwife identifies any physical, psychosocial, cultural and spiritual needs of the childbearing family.

Evaluation:

There were 367 (41.6%) of the 882 midwives who had practised during the past five years who indicated they used a problem solving approach in providing perinatal care. The setting of family orientated goals with input from the consumers was only practised by 212 (24%) of these midwives.

5.8.3 Standard 3 Health Education

The midwife provides health education for the mother, family and community as an integral part of midwifery care.

There are seven midwifery process behaviours described in the *Standards for the Practice of Midwifery (ACMI).* These will be used as performance criteria to evaluate midwives' participation in health education. The importance of the outcomes of midwifery processes is acknowledged again. The consequences of midwives' behaviours are discussed in Chapter Seven as qualitative findings.

Health Education Process Behaviours

5.8.3.1 Criterion 1:

The midwife provides relevant information to the mother, family and community so they may participate in and share responsibility for their own health promotion, maintenance and restorative care during pregnancy and labour, after birth, and interconceptually.

Evaluation:

Of the 606 midwives who had been involved in providing antenatal care there were 314 (51.8%) who had provided parent education for client groups. Individual client teaching while providing clinical antenatal care was given by 489 (80.7%) of these midwives.

During the intrapartum period there were 376 (57%) who said their care included intrapartum education for the childbearing women and their families.

Postnatal education was provided by 605 (76.1%) of midwives. There were 726 (91.3%) of these midwives who *assessed family processes and informational needs.* Education and information was provided by 93% (740) of midwives on postnatal self care, breast feeding, formula feeding, infant care, and community support services.

Parent education was provided in the domiciliary setting by 381 (47.9%) of midwives who had provided postnatal care during the past five years. There were 181 (22.9%) midwives who had been involved in promoting family focused health in the community setting; 347 (43.7%) had provided advice on contraception and 210 (26.4%) had assisted with family planning. Pre-conceptual care counselling had been provided by 166 midwives (27.4% of the 606 involved in antenatal care).

5.8.3.2 Criterion 2:

The midwife uses a problem solving approach to provide health education on an individual basis.

Evaluation:

As with the individual planning of perinatal care there were only 367 (41.6%) of the 882 midwives who had practised during the past five years who indicated they used a problem solving approach in providing health education. The setting of family orientated goals with input from the consumers was only practised by 212 (24%) of these midwives.

5.8.3.3 Criterion 3:

The midwife provides appropriate explanations and health education into the care of the high risk mother.

Evaluation:

During the antenatal period 482 (79.5% of the 606 midwives providing antenatal care) had cared for the high risk mother. Of those midwives providing antenatal care 339 (56%) had discussed a family orientated care plan with the high risk mother.

During labour midwives provided explanations of the care given to the high risk mother. There were 91.1% of midwives providing intrapartum care (n=660) who said they provided information about the physiological changes taking place during labour.

In the postnatal period 736 (92.3%) of midwives providing care to the sick neonate indicated they explained the rationale for the care procedures required.

5.8.3.4 Criterion 4:

The midwife provides mother and family with information needed to make decisions and choices about health care services, and establishes goals with the mother in order to maximise physical, functional, emotional, cultural and spiritual capabilities.

Evaluation:

Midwives (94%) provided parents with information regarding support services throughout all stages of pregnancy and childbirth, however, only 24% of practising midwives had been involved in establishing family orientated goals with the mother.

5.8.3.5 Criterion 5:

The midwife enhances health care by promoting continuity of health education, uses educational resources within the community.

Evaluation:

During the provision of domiciliary postnatal care there were 333 (46.5%) midwives who had referred families to community nursing services for ongoing support and health education. 42.1% had made referrals to medical practitioners, and 24.4% to allied health personnel:

Midwives (181 = 11.5%) involved in Child Health Services provided continuity in health education for the families for children up to 5 years.

5.8.3.6 Criterion 6:

The midwife works as an advocate with other health care providers to develop comprehensive holistic health care education.

Evaluation:

There were 339 (38.4% of 882 currently practising midwives) who said they acted as consumer advocates participating in continuous quality improvement to customer services. There was no direct indication from the survey data that midwives acted as

advocates to develop comprehensive holistic health care education. Chapter Seven discusses interview data on the advocacy role of the midwife in health care education.

5.8.3.7 Criterion 7:

The midwife promotes the role of the midwife as a health educator.

Evaluation:

The involvement of the midwife in all aspects of perinatal care as evidenced in the above data indicates the emphasis placed by midwives on their role as health educators. This is discussed further in Chapter Six.

5.8.4 Standard 4 Legislation, Policies and Procedures

The midwife formulates midwifery care in accordance with legislation, policies and procedures affecting practice.

Evaluation:

Midwifery practice throughout Australia is governed by the Nurses Acts within each state. Midwives participating in the survey were all registered with the Nurses Boards of each state.

Midwives perceived themselves to be practising following policies and procedures developed to regulate midwifery practice. The most frequently nominated level of input to policy and procedures formulating midwifery practice was indirect, little or no input (81% of practising midwives). Chapter Four *Descriptive Findings* details midwives' input to policies and procedures. The levels of autonomy midwives exercised in the performance of particular tasks are demonstrated in (Table 12 pp.81-82; Table 23 pp.93-96; and Table 34 pp.110-121). The impact of legislation, policies and procedures on midwives' practice is discussed in Chapter Seven.

Summary

The evaluation of Australian Midwives' practice against the components of the WHO *Definition of a Midwife,* and the *ACMI Standards for the Practice of Midwifery,* indicates a wide range in both the sphere of practice and the standards of practice.

There are consistencies throughout the evaluation indicating limitations in practice opportunities and lack of compliance with specific process criteria relating to standards of practice. problem approach to the care of the childbearing women and their families;These discrepancies between actual practice and the ACMI stated sphere of practice centre around four main issues. These are:

1. The perceived lack of input by midwives in determining the policies and procedures which dictate their practice;

2. A focus on fragmented *procedural* care of the women in preference to a holistic, family centred continuing model of care;

3. An ambivalence towards the ACMI Standards process criteria which emphasize a problem solving approach to the care of childbearing women and their families;

4. An inconsistency as a profession in participating in educational and experiential activities to ensure personal and professional development, and maintenance of current midwifery knowledge and skills.

These identified discrepancies between the ACMI stated sphere and standards of practice of midwifery, and the actual role of the midwife demonstrated through empirical data, are discussed in the following chapters.

CHAPTER SIX

FINDINGS - EXPLANATORY

6.1 Introduction

This chapter addresses the third research question of:

> *What are the facilitators and barriers to the enactment of the full potential role of the midwife as defined by The Australian College of Midwives Incorporated in the Standards for the Practice of Midwifery (1989)?*

The previous chapter has evaluated midwives' practice against the components of the sphere of practice as described by the International Definition of a Midwife (1976), and the *Standards for the Practice of Midwifery* (ACMI, 1989). The findings indicate a wide range in the compliance with the *Standards*, and a diversity of opinion on the International Definition of a Midwife (WHO, 1976), included in the standards, as a descriptor of the role of the Australian midwife (Table 41 p.129). There were 1.9% (33 of 1754) who said it was not a good description, while a further 13.5% (238) offered no opinion. On the contrary 386 (22%) thought the standards described current Australian midwives' practice. The majority of responses however, (847 = 48.3%) indicated that *the definition* was an ideal to aim for but currently not completely practised by Australian midwives.

There were 250 (14.5%) who responded to the invitation to comment on factors they considered inhibited them practising to the full extent of the International Definition of a Midwife (WHO, 1976). These comments were entered to the *Ethnograph* program (Seidel, Kjolseth and Seymour, 1988) for sorting and retrieval using content analysis methodology. Eight categories were identified through sorting comments into categories with common properties. Table 42 (p.130) summarises the 264 specific factors identified by midwives as inhibiting them from fulfilling the International Definition of a Midwife and the sphere of practice, as stated in the *Standards for the Practice of Midwifery* (1989). These factors are illustrated here, with typical examples of comments relating to the identified categories of inhibiting factors, presented in frequency order.

6.2 Medical dominance

There were 60 specific comments relating to the inhibiting influence of medical dominance on the ability of midwives to practise according to the International Definition of a Midwife. The following short comments typify those given by the 60 midwives.

> *Due to medical dominance the midwife has under utilized her skills and knowledge.*
>
> *Because we are over doctored it will be some time before we can achieve the definition i.e. too much competition and historically so.*
>
> *Obstetricians still prevent midwives from reaching their complete roles.*
>
> *Medical dominance and power prevents midwives from practising according to the definition.*
>
> *Medical dominance not allowing for midwife deliveries and antenatal clinics/care.*

6.3 Lack of opportunity to practise in all areas

There were 47 comments that indicated the inhibiting effect of the lack of opportunity to practise in all areas. In addition, the effects of specialisation (13 comments), and lack of continuity (12 comments), had the same effect as situations described specifically as *lack of opportunity to practise in all areas.* Examples of these three aspects of limited practice opportunities are as follows:

> *I think Australian midwives are capable of fulfilling this definition but do not have the opportunity to do so.*
>
> *Midwives in Australia tend to be engaged to work in a particular area e.g. post natal but not antenatal, family planning etc.*
>
> *My inability to encompass all aspects of the WHO definition relates mostly to my employment in "pool". This means little continuity of patient care and a lack of opportunity to practise skills I had previously gained.*
>
> *I feel Australian midwives are not given the opportunity to utilise all the skills they were taught. They do not have enough autonomy or independence and get slotted into boxes of clinical practise in hospitals.*

There is a greater need for involvement in antenatal care and long term follow up after discharge.

Such ideals will only be reached if staff rotate through all the areas of midwifery care. Otherwise skills and knowledge quickly diminish.

Once completing a midwifery course most Australian midwives tend to specialize in one area. Thus you are no longer up to date or competent to give adequate independent care to , for example, women in labour.

6.4 The effect of practice settings

There were 37 comments on how the midwives considered their sphere of practice to be limited within various settings, as demonstrated in the following quotes:

Limited by places of employment. Large hospitals have staff specialising, rural hospitals tend to offer more scope - particularly for sole practitioners.

Depending on where one is working one can just be an "obs" taker. Decisions often fully controlled by the GP/Obstetricians. This tends to be in places where medical intervention is quite high, thus decreasing our role, I feel.

Practice varies from state to state. Some states and hospitals would meet the criteria and some wouldn't. Bush nurses/midwives probably would.

Things are gradually improving with the introduction of domiciliary care and midwives' clinics.

Is practised by independent midwives, not hospital employed midwives.

My midwifery experience has been mainly in a small country unit where our practice is not hampered by small minds or bureaucracy.

In large hospitals antenatal, intrapartum, postnatal and the puerperium become separated roles, but in small and isolated hospitals the midwife has continuity of these stages.

Working in a private hospital means our autonomy is threatened and we do not conduct deliveries unless the doctor is unavailable.

Lack of opportunity to practise in all areas of midwifery affected midwives' confidence to practise *on their own responsibility.* This midwife expressed her concern, summarising the statements of other midwives.

> *Many midwives such as myself working in large metro maternity hospitals have a narrow field of experience e.g. postnatal care, due to lack of rotation through all areas of the unit. Even though I have practised as a "midwife" for 12 years I would feel very reluctant to conduct a delivery "on my own responsibility" due to lack of practice.*

6.5 Lack of confidence

Lack of confidence was expressed as an inhibiting factor on fulfilling the *International Definition of a Midwife, and the Sphere of Practice.* Typical examples in the data included the following comments:

> *I don't believe most Australian midwives practise autonomously taking full responsibility, and most lack confidence to do so.*
>
> *Fragmentation of the midwives' role in hospitals has done much to destroy their confidence.*
>
> *I believe Australian midwives are ambivalent re their role. They would like more responsibility on one hand yet have lost confidence in their skills on the other due to medical practice "taking over" their potential role.*
>
> *Not given the opportunity to work and practise in all areas I am not competent and confident.*
>
> *Midwives tend to exclude themselves from neonatal intensive care and delivery unit, due to lack of perceived expertise and having not worked in these areas for sometime.*

6.6 Regulations, policies and procedures

The descriptive findings in Chapter Four demonstrated the controlling influence of policies and procedures on midwives' practice. The most frequently nominated level of practice autonomy for procedures throughout antenatal, intrapartum and postnatal care was *self performed following policies and procedures.* The following comments made

by midwives illustrate the effect of policies and procedures on their ability to practise to the full extent of the International Definition of a Midwife.

> *I have the knowledge and skills to fulfil the WHO's definition of a midwife but am prevented from doing so by restrictive Victorian regulation.*
>
> *Australian midwives are subject to regulations which vary from state to state which affects their scope of practice.*
>
> *I believe that the medical profession feel threatened by midwife practitioners and legislation prevents midwives from conducting deliveries on their own responsibility.*
>
> *Restricted by obstetricians lack of support and policies of the unit.*
>
> *Depending on policies and procedures of hospital or work place, availability of staff and work load, support of both nursing and medical management, the definition of a midwife is too frequently fragmented.*
>
> *Delivering on her own responsibility depends on hospital policy. Some hospitals require that an obstetrician be summoned for public patients.*

6.7 Lack of autonomy

The descriptive data indicating the perceived level of practice autonomy for specific tasks was provided in Chapter Four. Following the classification of *self performed following policies and procedures, autonomous decision making* was the second ranked level of antenatal, intrapartum and postnatal task performance. Midwives'comments did not support the high perception of independent practice indicated through the numerical data. The following comments illustrate this anomaly:

> *Working in a large level 3 hospital, a proportion of decisions for care has to be balanced with medical officers and their inclusion in normal pregnancies and deliveries.*
>
> *Restrictions on midwives autonomy. AMA only happy for midwives to be employees with them in control.*
>
> *The Australian midwife unless practising independently doesn't experience autonomy.*

Australian midwives, possibly as a result of the historic tie to nursing (midwifery nurses) have traditionally lacked the degree of autonomy in practice expected of many overseas midwives.

We still have a long way to go particularly in role as independent practitioners.

Independent practitioners with rebate care long overdue.

This is an enormous amount of responsibility and not to be taken lightly.

Some midwives may prefer not to take on board such responsibilities.

6.8 Lack of community recognition

Comments relating to the effect of lack of recognition of the midwife's role by the community were often linked to the lack of recognition by the medical profession and other health professionals. The following comments illustrate this:

Victorian midwives still have not been able to be considered as practitioners in their own right. Greater recognition from other health care teams and the community is essential.

The public are still educated to think obstetrician first, then the hospital, then nurses are an addition that hospitals provide.

Difficult to see midwives ever fully practising as long as medical resistance and community ignorance to our role exists.

Worked in a town where the expectation of the general public and institution was that doctors deliver babies, and midwives only if the doctor isn't in time, in which case this is a lesser option.

Culturally Australian women choose an obstetrician for confinement probably due to lack of knowledge of skills of midwives.

6.9 Other comments

Other comments made by midwives were related to personal experience and its effect on their sphere of practice. Comparisons were made between practice opportunities in the United Kingdom and Australia. These comments often reflected a degree of frustration by the UK midwives practising in Australia.

Australian midwives are constrained within the medical model of the Australian system - speaking as one who has worked in Australia and the UK.

I am reluctant to take full time position as a midwife, due to restrictions imposed, as opposed to in the UK.

The UK midwife has more responsibility and more job satisfaction.

I trained in Australia and worked in the UK for a short time as a midwife. I feel Australian midwives are not competent (not enough knowledge and skills) to work as midwives.

Having trained in Scotland, I found it hard initially conforming to the obstetric dominance of Australian midwifery practice.

6.10 Importance ranking of requirement factors to meet the International Definition of a Midwife (WHO, 1976).

Midwives participating in the survey were asked to rate the importance of eight factors as requirements to help them practise to the full extent of the internationally defined sphere of practice.

The percentage ratings of the importance of each of these factors is given in Table 54 (p.169). Each of these factors is presented here in the order in which they were ranked as being important as requirements for midwives to practise to the full extent of the international definition.

While a higher rating of importance was given to these factors by the interview group of midwives, the ranking of the order of importance was the same as the randomly selected survey sample. Association between the ratings given by the two groups of *employed in past five years (EP5)* and *not employed as a midwife in the past five years (NEP5)* was tested using crosstabulations procedure. The Pearson chi-square probability ($p<.05$) was used to indicate the significance of the association between ratings given by the two groups.

Table 54

Requirements to Meet the International Definition of a Midwife.

n=1754

FACTOR	IMPORTANCE RATING	%
Increased Opportunities For Continuing Education	Missed Response	13.7%
	Not Important	0.1%
	Fairly Important	1.6%
	Important	25.9%
	Essential	58.6%
Opportunity to Provide Care at All Stages	Missed Response	13.1%
	Not Important	0.4%
	Fairly Important	2.3%
	Important	23.4%
	Essential	60.8%
Greater Recognition of Midwifery Knowledge & Skills by Medical Profession	Missed Response	13.5%
	Not Important	0.2%
	Fairly Important	2.4%
	Important	22.6%
	Essential	61.3%
Greater Recognition of Midwifery Knowledge & Skills by the Community	Missed Response	13.5%
	Not Important	0.6%
	Fairly Important	4.5%
	Important	34.3%
	Essential	47.0%

Table 54 Continued

FACTOR	IMPORTANCE RATING	%
Greater Recognition of Midwifery Knowledge & Skills by Nursing Profession	Missed Response	13.6%
	Not Important	0.6%
	Fairly Important	5.6%
	Important	34.3%
	Essential	46.0%
Decreased Medical Intervention in Normal Childbirth	Missed Response	14.7%
	Not Important	2.9%
	Fairly Important	8.6%
	Important	37.3%
	Essential	36.5%
Changes to Organisational Policies and Procedures	Missed Response	16.5%
	Not Important	1.7%
	Fairly Important	13.5%
	Important	42.4%
	Essential	25.9%
Changes to Legislation	Missed Response	15.3%
	Not Important	2.7%
	Fairly Important	14.5%
	Important	40.0%
	Essential	26.5%

In addition to rating their perceptions of the importance of the 8 nominated factors, midwives were invited to include comments on any of these factors. These comments have been analysed using a content analysis procedure and are summarised following the numerical findings. Those midwives who did not respond to some of the questions in this section stated that they did not have sufficient knowledge of a particular question,

or questions, to be able to give an informed opinion. This explains the large number of missed responses from those midwives who had not practised during the past five years.

6.10.1 Increased opportunities for continuing education

Of the 1754 randomly selected sample of midwives 1028 (58.6%) rated increased opportunities for continuing education as being essential, while another 455 (25.9%) stated that it was important. Excluding missed responses there was a 0.1% (n=2) rating that indicated increased opportunities for continuing education as not important. Table 55 below provides comparative ratings given by the EP5, NEP5, and Interview group, of midwives. Using the crosstabs procedure and controlling for the high number of missed responses from the NEP5 group there was no significant difference (X^2 3.725 DF 6 p .7137) between the ratings given by those midwives employed during the past five years (n=882) and those who had not worked as a midwife for the past 5 years (n=864). Midwives from the group purposively (and theoretically) selected for interviews gave a much higher rating of the importance of increased opportunities for continuing education as a requirement for midwives to fulfil the International Definition of a Midwife.

Table 55 Comparative Ratings of the Importance of Increased Opportunities for Continuing Education.

Rating	EP5.		NEP5.		Interview	
	f	%	f	%	f	%
Missed Response	23	2.6	214	24.8	0	0.0
Not Important	2	0.2	0	0.0	0	0.0
Fairly Important	19	2.2	9	1.0	0	0.0
Important	264	29.9	191	22.1	10	18.9
Essential	574	65.1	450	52.1	43	81.1

6.10.2 Opportunity to provide care throughout all stages of pregnancy and childbirth

There were 1067, (60.8%) midwives, who considered opportunities to practise throughout all stages of pregnancy and childbirth as essential to fulfil the international definition of the sphere of practice. A further 410 (23.4%) considered this important; 41 (2.3%) fairly important; and 7 (.4%) did not rate opportunities to practise throughout all stages as important. Table 56 below shows comparative ratings between the three groups. Again using the crosstabs procedure and chi square statistic the different ratings between the two groups *(EP5,* and *NEP5)* were not statistically significant (X^2 .54045 DF 6 p .997). The midwives selected for interviews gave a much higher rating than the randomly selected midwives.

Table 56 Comparative Ratings of the Importance of Increased Opportunities to Provide Care Throughout all Stages of Pregnancy and Childbirth

Rating	EP5.		NEP5.		Interview	
	f	%	f	%	f	%
Missed Response	22	2.5	202	23.5	0	0.0
Not Important	4	0.5	3	0.3	0	0.0
Fairly Important	23	2.6	18	2.1	0	0.0
Important	238	27.0	170	19.7	10	18.9
Essential	595	67.5	470	54.5	43	81.1

6.10.3 Greater recognition of midwifery knowledge and skills by the medical profession

It was considered essential by 61.3% of the 1754 randomly selected midwives that there should be a greater recognition of their practice by the medical profession if midwives are to practise to the full extent of the International Definition of a Midwife and the sphere of practice. A further 22.6% thought greater medical recognition was important, and 2.4% said it was fairly important. Only .2% did not consider it important.

There was not a significant difference between the *EP5,* and *NEP5* groups, to the question of recognition (X^2 10.8722 DF 6 p .09241). A difference in the two groups is demonstrated by the 212 missed responses from the NEP5 group compared with the

EP5 20 missed responses (Table 57 p. 173). There were 73.1% of the *EP5* group who considered greater recognition from the medical profession essential compared with 49.4% from the *NEP5* group, as shown in Table 57 below.

Table 57 Comparative Ratings of the Importance of Greater Recognition of Midwifery Knowledge and Skills by the Medical Profession.

Rating	EP5.		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	20	2.3	212	24.6	0	0.0
Not Important	2	0.2	2	0.2	0	0.0
Fairly Important	23	2.6	19	2.2	0	0.0
Important	192	21.8	204	23.6	10	18.9
Essential	645	73.1	427	49.4	43	81.1

6.10.4 Greater recognition of midwifery knowledge and skills by the community

There were 47% of the 1754 randomly selected midwives who rated greater recognition of midwifery knowledge and skills as essential if midwives were to practise to the full extent of the international definition. A further 34.3% said it was an important factor; 4.9% fairly important, and .6% did not consider it important.

Again, controlling for missed responses, there was a statistically significant difference (X^2 23.4691 DF 6 p .00065) between the *EP5* and the *NEP5* groups. Those who had been employed as a midwife during the past five years were more likely to give a higher rating of importance than those who had not practised during this time. The interview group gave the highest rating of importance. (Table 58 p.174).

Table 58 Comparative Ratings of the Importance of Greater Recognition of Midwifery Knowledge and Skills by the Community.

Rating	EP5		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	22	2.5	212	24.6	0	0.0
Not Important	5	0.6	5	0.6	0	0.0
Fairly Important	43	4.9	36	4.2	0	0.0
Important	292	33.1	309	35.8	10	18.9
Essential	520	59.0	302	35.0	43	81.1

6.10.5 Greater recognition of midwifery knowledge and skills by the nursing profession

There were 46% of the survey sample who rated greater recognition by the nursing profession as an essential requirement to enable them to meet the international definition; 34.3% said it was an important requirement, and 5.6% considered it fairly important. In comparison 0.6% said it was not important, and a further 13.5% gave no response. Although it was evident from the frequencies (Table 59 below) that a greater number of the *EP5 group* gave a higher rating of importance to recognition from the nursing profession, there was no statistically significant association demonstrated using the crosstabs procedure (X^2 3.368 DF 6 p .7614).

Table 59 Comparative Ratings of the Importance of Greater Recognition of Midwifery Knowledge and Skills by the Nursing Profession

Rating	EP5		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	21	2.4	213	24.7	0	0.0
Not Important	4	0.5	7	0.8	0	0.0
Fairly Important	57	6.5	41	4.7	1	1.9
Important	327	37.1	273	31.6	13	24.5
Essential	473	53.6	330	38.2	39	73.6

6.10.6 Decreased medical intervention in normal childbirth

Decreased medical intervention in normal childbirth was considered essential by 641 (36.5%) of the surveyed midwives. There were 655 (37.3%) who rated this factor important as affecting their ability to function to the full extent of the international definition, and 150 (8.6%) thought it was fairly important. There were 50 midwives (2.9%) who did not think it an important requirement, and 63 (3.6%) did not respond to the question.

There was a statistically significant difference (X^2 70.1772 DF6 p.0000) between the ratings given by those midwives who had practised in the past five years *(EP5)* and those who had not *(NEP5)*. Of those who had, 450 (51%) said it was essential that there be decreased intervention in normal childbirth if midwives were to practise to the full extent of the WHO definition; 336 (38.1%) thought it was an important requirement; 53 (6%) fairly important, and 17 (1.9%) did not consider it an important factor. Those midwives who had not practised for the past five years *(NEP5)* had a much lower rating of the effect of medical intervention on the ability of the midwife to practise to the full extent of the international definition. There were only 189 (21.9%) who considered it essential; 318 (36.8%) who said it was important; 96 (11.1%) fairly important, and 3.8% did not consider it important. In addition, there was an increase in the number of missed responses (26.4%), as can be seen in Table 60 below.

Table 60 Comparative Ratings of the Importance of Decreased Medical Intervention in Normal Childbirth.

Rating	EP5		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	26	2.9	232	26.4	0	0.0
Not Important	17	1.9	33	3.8	0	0.0
Fairly Important	53	6.0	96	11.1	2	3.8
Important	336	38.1	318	36.8	13	24.5
Essential	450	51.0	189	21.9	38	71.6

6.10.7 Changes to organisational policies and procedures

Of the randomly selected sample of midwives 455 (25.9%) rated changes to policies and procedures an essential requirement to allow midwives to meet the practice sphere of the international definition. A larger number 743 (42.4%) said it was an important requirement; 237 (13.5%) considered it fairly important, while 30 (1.7%) rated it unimportant. A further 289 (16.5%) did not respond to the question.

On comparing the two groups *EP5* and *NEP5*, using the crosstabs procedure, there was a significant difference (X^2 18.6399 DF 6 p .0048) in the ratings. Those who had practised in the past five years considered the effect of organisational policies on their ability to practise to the international definition of more importance than those who had not practised. There were also more missed responses for the *NEP5* group (253=29.3%). (See Table 61 below).

Table 61 Comparative Ratings of the Importance of Changes to Organisational Policies and Procedures.

Rating	EP5		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	32	3.6	253	29.3	0	0.0
Not Important	19	2.2	11	1.3	0	0.0
Fairly Important	123	13.9	113	13.1	4	7.5
Important	415	47.1	326	37.7	19	35.8
Essential	293	33.2	161	18.6	30	56.6

6.10.8 Changes to legislation to remove restrictions affecting the midwives' practice domain

The removal of restrictive legislation controlling the midwives' practice was considered to be essential by 465 (26.5%) of midwives, and important by 701 (40%). A further 255 (14.5%) considered it a fairly important requirement, while 47 (2.7%) did not think it important. There were 286 (16.3%) missed responses to this question.

Using the crosstabs procedure, and controlling for missed responses, there was not a significant association between ratings given by those who had been employed in

the past five years and those who had not (X^2 9.9417 DF 6 p .1271). There were more missed responses to this question than to the other identified factors considered to affect the midwives' ability to practise according to the international definition of the midwives' sphere of practice. Table 62 below, compares the ratings between groups.

Table 62 Comparative Ratings of the Importance of Changes to Legislation.

Rating	EP5		NEP5		Interview	
	f	%	f	%	f	%
Missed Response	34	3.8	248	28.7	0	0.0
Not Important	27	3.1	20	2.3	1	1.9
Fairly Important	132	15.0	123	14.2	2	3.8
Important	400	45.4	298	34.5	16	30.2
Essential	289	32.8	175	20.3	34	64.2

6.11 Midwives' level of satisfaction with identified factors as applied to individual practice

Midwives responding to the questionnaire survey were asked to consider their level of satisfaction, within their own practice, with the eight nominated factors they had given ratings of importance as requirements to enable midwives to practise to the full extent of the international definition of the sphere of practice of a midwife. Their numerical responses are given here with examples typifying accompanying comments. Each factor is presented in the order of lowest to highest levels of satisfaction with the effect on their practice. Midwives who had not practised within the past 5 years were given the option of considering their satisfaction with these factors during their years of practice. There was a high percentage of missed responses to this question from the NEP5 group.

Table 63 (pp.178-180) shows the ranking of satisfaction with these factors given by the randomly selected sample of midwives.

Table 63 Satisfaction with Requirements to Meet the WHO Definition of a Midwife.

n=1754

FACTOR	SATISFACTION RATING	%
Satisfaction with the Level of Medical Intervention	Missed Response	22.6%
	Dissatisfied	2.6%
	Little Satisfaction	24.3%
	Mostly Satisfied	32.9%
	Well Satisfied	3.7%
	Highly Satisfied	0.9%
Recognition of the Midwife's Knowledge and Skill by the Medical Profession	Missed Response	22.3%
	Dissatisfied	9.7%
	Little Satisfaction	28.2%
	Mostly Satisfied	31.5%
	Well Satisfied	7.1%
	Highly Satisfied	1.1%
The Effect of Organisational Policies and Procedures on the Midwife's Potential to Practice	Missed Response	24.4%
	Dissatisfied	4.6%
	Little Satisfaction	21.7%
	Mostly Satisfied	40.8%
	Well Satisfied	8.0%
	Highly Satisfied	0.6%

Table 63 Continued

FACTOR	SATISFACTION RATING	%
Recognition of the Midwife's Knowledge and Skills by the Community	Missed Response	22.4%
	Dissatisfied	3.6%
	Little Satisfaction	24.5%
	Mostly Satisfied	37.4%
	Well Satisfied	10.6%
	Highly Satisfied	1.5%
Midwives' Satisfaction with the Effect of Legislation on their Potential to Practice	Missed Response	25.1%
	Dissatisfied	4.4%
	Little Satisfaction	18.1%
	Mostly Satisfied	42.0%
	Well Satisfied	9.6%
	Highly Satisfied	0.7%
Midwives' Satisfaction with their Opportunities to Provide Care Throughout all Stages of Pregnancy and Childbirth	Missed Response	20.6%
	Dissatisfied	4.2%
	Little Satisfaction	22.5%
	Mostly Satisfied	37.7%
	Well Satisfied	11.6%
	Highly Satisfied	3.4%

Table 63 Continued

FACTOR	SATISFACTION RATING	%
Midwives' Satisfaction with their Present Level of Knowledge and Skills	Missed Response	22.0%
	Dissatisfied	7.8%
	Little Satisfaction	21.7%
	Mostly Satisfied	40.1%
	Well Satisfied	14.1%
	Highly Satisfied	2.1%
Midwives' Satisfaction with the Recognition of their Knowledge and Skills by the Nursing Profession (incl. Midwives).	Missed Response	22.1%
	Dissatisfied	2.6%
	Little Satisfaction	12.5%
	Mostly Satisfied	44.0%
	Well Satisfied	17.0%
	Highly Satisfied	1.8%

6.11.1 Satisfaction with the level of medical intervention

As demonstrated in Table 63 (p.178) this factor affecting the personal experiences and practice of midwives rated the lowest level of satisfaction. Of the 1754 randomly selected survey sample there were 37.5% who expressed satisfaction with the level of medical intervention and its effect on the midwife's potential to practise to the extent defined by the international definition of a midwife and the sphere of practice. The large number of missed responses to the question is explained in the differences between the two groups i.e. those who had practised in the past 5 years *(EP5)* and *(NEP5)*, those who had not.

The most marked difference between midwives *EP5* and those *NEP5* was in the number of missed responses from the *NEP5* group. Comments written by these midwives showed that they did not consider their past experience to be adequate or

relevant enough to the current practices to give an informed opinion. Of those *NEP5* midwives who did respond to the question directly there was no statistically significant difference (X^2 4.222 DF 6 p .6446) with their levels of satisfaction to those of the *EP5* group.

Midwives who had practised during the past five years gave the following ratings of satisfaction to the effects of medical intervention on their practice: 173 (19.6%) were dissatisfied; 279 (31.6%) had little satisfaction; 347 (39.3%) were mostly satisfied; 32 (3.6%) well satisfied, and 10 (1.1%) highly satisfied. There were 41 (4.7%) missed responses.

Table 64 Midwives Comparative Satisfaction with the Level of Medical Intervention.

	EP5		NEP5		Interview	
RATING	f	%	f	%	f	%
Missed Response	41	4.7	351	40.6	2	3.8
Dissatisfied	173	19.6	101	11.7	19	35.8
Little Satisfaction	279	31.6	146	16.9	16	30.2
Mostly Satisfied	347	39.3	228	26.4	13	24.5
Well Satisfied	32	3.6	33	3.8	3	5.7
Highly Satisfied	10	1.1	5	0.6	0	0.0

The diverse factors affecting the levels of satisfaction expressed by midwives are highlighted by the additional comments written in the open section of the questionnaire. There were 153 comments related specifically to midwives' dissatisfaction with the level of medical intervention on their practice. Examples of these comments follow.

Midwives were concerned about the failure to recognize what they called *normal childbirth*. Normal childbirth was described as :

--- pregnancy, labour and birthing are normal biological processes. Medical intervention should only be taken when complications arise.

and

With good midwifery knowledge and skills, a midwife should be able to deal with normal childbirth without any medical intervention.

Examples were given of midwives' experiences with what they perceived to be *unnecessary intervention.*

Too many unnecessary Caesareans catered around the specialist's timetable rather than the mothers' and babies' needs.

This was often referred to as *convenience obstetrics* as the following excerpts demonstrate.

Too many births are conducted to meet medical staff's agendas for golf and the like.

Medical staff in my experience intervene to suit their own needs not that of the mother.

"9-5" obstetrics to be outlawed. But anything approved that is for the benefit of mother and child should not be held back if necessary.

Midwives commented on the adverse affects of *unnecessary intervention* on mothers and babies, and also on midwives themselves. As this midwife stated:

Continuing medical intervention is unnecessary and often has some negative experiences for all concerned which also includes the attending midwives.

The effect of medical intervention in normal childbirth on the midwives'practice is discussed in Chapter Seven - Qualitative Findings.

6.11.2 Recognition of the midwife's knowledge and skill by the medical profession

In response to the question of how they would rate their satisfaction with the recognition of their knowledge and skill by the medical profession 20 (1.1%) said they were highly satisfied; 125 (7.1%) were well satisfied, and 552 (31.5%) were mostly satisfied. There were 495 (28.2%) who said they had little satisfaction and 170 (9.7%) were dissatisfied. As shown in Table 65 (p.183) there were 41% of the NEP5 group who did not respond.

Controlling for missed responses there was not a significant difference, using the procedure crosstabs, between the ratings given by the *EP5* and the *NEP5* groups (X^2 7.278 DF 6 *p*.2958). The midwives purposively and theoretically selected for interviews showed more dissatisfaction with the level of recognition by the medical profession of their knowledge and skills than those midwives randomly selected to participate in the questionnaire survey.

Table 65 Midwives Comparative Satisfaction with Recognition of Their Knowledge and Skills by the Medical Profession.

	EP5		NEP5		Interview	
RATING	f	%	f	%	f	%
Missed Response	34	3.9	354	41.0	2	3.8
Dissatisfied	88	10.2	82	9.5	10	18.9
Little Satisfaction	310	35.1	184	21.3	21	39.6
Mostly Satisfied	358	40.6	192	22.2	14	26.4
Well Satisfied	80	9.1	44	5.1	5	9.4
Highly Satisfied	12	1.4	8	0.9	1	1.9

The effect of lack of recognition by the medical profession is demonstrated by the following comments made by midwives participating in the survey.

> *Obstetricians do not appear to value our knowledge and skills and encouragement of women to have natural births or alternative positions etc.*
>
> *Medical personnel need to acknowledge the ability of the midwife being able to practise safely without routine referral to them.*
>
> *Medical professionals and patients are to place more trust in the midwife enabling safer outcomes at a more relaxed pace organised by clinical signs and symptoms, not amount of time available and other inconveniences that speed up delivery time.*

Midwifery cannot progress unless the medical profession respect the role of the midwife.

I feel the greatest barrier to midwives being recognised professionally is the medical profession.

6.11.3 The effect of organisational policies and procedures on the midwife's potential to practise

There was no statistically significant difference between midwives who had practised during the past 5 years *(EP5)* and those who had not *(NEP5)* regarding their levels of satisfaction on the effect of organisational policies and procedures on their potential to practise (X^2 7.619 DF 6 p .2672). The majority (715 = 40.8%) said they were *mostly satisfied.* There were more expressing negative satisfaction levels (461 = 26.3%) than positive (150 = 8.6%).

Comments included:

To achieve the all round status needed to practise safe midwifery organisational policies etc. must be changed.

I feel very much that Australian midwives are seen as obstetric nurses with impeded autonomy. My perception is that of an imbalance of power within hospitals in regards to policy decision making.

Although hospital policies and procedures are essential they put limitations on what we are allowed and not allowed to perform independently.

Hospital policy and state restrictions impede to an extent, the care a midwife can give i.e. inability to perform unsupervised vaginal examinations, rupturing of membranes, and suturing of perineum.

Too much conflicting information, mainly hospital policies that seem to change from hour to hour, therefore, patients get conflicting advice, and we have a vicious circle.

Little opportunity for autonomous decision making within the hospital setting, being bound by hospital/midwifery standards of practice.

6.11.4 Recognition of the midwife's knowledge and skills by the community

The most frequently expressed level of satisfaction with recognition of midwives' knowledge and skills by the community was *mostly satisfied* (656 = 37.4%). Satisfaction levels from this medial rating were more frequently towards *little satisfaction or dissatisfaction* (492 = 28.1%) than towards *well satisfied or highly satisfied* (213 = 12.1%). There was no statistically significant difference (X^2 5.9945 DF 6 p.4238) between the *EP5* and *NEP5* groups.

Qualifying comments made by the midwives are illustrated by the following typical excerpts:

> *It appears a great problem is due not only to medical dominance but it spreads to the perception of the general public who unfortunately see pregnancy and delivery etc. something where a doctor is "always best" - must be at delivery etc..*
>
> *The community needs to be made more aware of midwives' skills and there needs to be provision made for more independent practitioners.*
>
> *I believe midwives need to become independent practitioners and autonomous so that they are recognized for the valuable service they can provide in this over rationalistic and technological society.*

There were comments that referred to the inaccessibility of the midwives during the antenatal period. This factor was seen as influencing the perceptions of the childbearing women of the midwife's role. The following two excerpts express this idea:

> *A lot of patients are not educated in birth /pregnancy/antenatal care etc. and therefore in this catchment area do not appreciate the role of the midwife.*
>
> *I feel the community would recognize midwifery skills and knowledge if they were more able to demonstrate them without restrictions.*
>
> *I am pregnant and seeing a private obstetrician. The only midwife I have come in contact with is the booking sister at the hospital. This would be*

the same for most private patients and would explain their lack of recognition of our knowledge and skills.

The experiences of the next midwife, who worked in a birth centre, had given her a different perception of the recognition of midwives' knowledge and skills. She stated:

The community, I feel, are very aware of the knowledge and skills of midwives. Having only a midwife during labour and delivery is much preferred than having medical intervention.

6.11.5 Midwives' satisfaction with the effect of legislation on their potential to practise

There was a high number of missed responses to this question. There were also less comments made in the open comments section. Of those midwives who had not practised during the past 5 years *(NEP5)* 375 (43%) did not give an opinion. Of those who had been employed *(EP5)* 62 (7%) did not respond. On comparison of the findings of these two groups, using the crosstabs procedure and controlling for missed responses, there was no significant difference in their levels of satisfaction with the effect of legislation on their practice potential (X^2 7.856 DF 6 p .2488). There were 1313 (74.9%) of the randomly selected survey group who provided the following data: 736 (42%) *mostly satisfied*; 169 (9.6%) *well satisfied*; 12 (.7%) *highly satisfied;* with 18.1% having *little satisfaction* and 78 (4.4%) *dissatisfied.*

Midwives' perceptions of the effect of current legislation on their practice are reflected in these examples of comments made in the open sections of the questionnaire. Although the first comment refers to Australian midwives all comments relating specifically to the effect of legislation on their potential to practise to the full extent of the international definition of the sphere of practice, referred directly to the old Victorian legislation (Nurses Act 1958, and Midwives Regulations 1985).

Australian midwives are subject to regulations which vary from state to state, which affects their scope of practice. Independent midwives in Victoria seem most restricted, reflected in low home birth rate in Victoria.

I believe that the medical profession feel threatened by midwife practitioners and legislation prevents midwives from conducting deliveries on "their own responsibility".

We do all the "work" in supporting the women, however there is a limit to the full use of our skills (legal limit). Rules need to change!

Midwifery practice I feel currently is threatened enormously due to both continuing dominance and the current state and federal policies. Particularly the potential change to the Victorian Nurses Act.

Working in the private hospital system reduces my involvement in antenatal care because of present legislation restrictions on midwifery practice in Victoria and lack of rebate for services through Medicare.

6.11.6 Midwives' satisfaction with their opportunities to provide care throughout all stages of pregnancy and childbirth

Satisfaction ratings with the opportunities to provide care throughout all stages of pregnancy and childbirth, see Table 66 (p.188) centred around *mostly satisfied* (f = 662 = 37.7%). The percentages expressing *little satisfaction* (22.5%) and *dissatisfied* (4.2%) were greater than those expressing *well satisfied* (11.6%) and *highly satisfied* (3.4%).

Controlling for the large number of missed responses (37%) from the EP5 group there was not a significant association between the *EP5* midwives and the *NEP5* group's expressed levels of satisfaction with their opportunities to provide care throughout all stages of childbirth (Crosstabs procedure X^2 5.625 DF 6 p .4664). Midwives from the group selected for interviews indicated higher levels of satisfaction with their opportunities to practise throughout all stages of pregnancy and childbirth than those midwives participating in the randomly selected survey group, see Table 66, (p.188).

Table 66 Midwives Comparative Satisfaction with Their Opportunities to Provide CareThroughout all Stages of Pregnancy and Childbirth

	EP5		NEP5		Interview	
RATING	f	%	f	%	f	%
Missed Response	38	4.3	320	37.0	1	1.9
Dissatisfied	35	4.0	38	4.4	2	3.8
Little Satisfaction	234	26.5	159	18.4	13	24.5
Mostly Satisfied	419	47.5	242	28.0	18	34.0
Well Satisfied	126	14.3	77	8.9	10	18.9
Highly Satisfied	30	3.4	28	3.2	7	13.2

Comments made in the open sections of the questionnaire related to different factors midwives felt influenced their opportunities to provide care throughout all stages of pregnancy and childbirth, and the effect this had on their level of satisfaction. The diversity of these factors is indicated in the following excerpts:

> *Unable at present as an associate Charge Midwife to rotate to labour ward despite expressed interest. Should be rotating to all areas.*
> *Would like to do more deliveries myself - not just assist - otherwise am well satisfied with my opportunity to utilise skills and knowledge.*
> *Antenatal skills not used - due to no rotation through the various areas of midwifery.*
> *No rotation within departments therefore skills not used.*
> *Limited by places of employment - large hospitals have staff specialising. Rural hospitals tend to offer more scope.*
> *The way most hospitals work it is not possible to follow women antenatally right through.*
> *We look after our antenatal patient up to or into second stage then they go to delivery suite. It is very disappointing to care for a woman through most of her labour and then not be able to stay with her for delivery.*

Many of the comments made concerning opportunities to practise throughout all stages of childbirth were related to other factors affecting the midwives' sphere of practice already identified in this chapter. The interrelationships between factors will be discussed in the following chapter.

6.11.7 Midwives' satisfaction with their present level of knowledge and skills

There was a significant association (Crosstabs procedure X^2 225.950 DF 6 p .0000) between EP5 and NEP5 midwives' levels of satisfaction, within their own experience and practice, of their knowledge and skills to be able to practise to the full potential of the internationally defined sphere of the midwife. Table 67 (below) shows that of the midwives who had practised during the past 5 years there were 459 (56.1%) who were mostly satisfied with the effect of their level of knowledge and skills on their sphere of practice; 211 (23.9%) *well satisfied,* and 30 (3.4%) *highly satisfied.* There were 85 (9.6%) who expressed little satisfaction with their level of knowledge and skills, and 21 (2.4%) were *dissatisfied.* In comparison there were 24% of the *NEP5* group who said they were *mostly satisfied;* 3.9% *well satisfied* and .7% *highly satisfied.* Of this group who had not practised as a midwife during the past 5 years 18.3% expressed *little satisfaction* with the effect of their level of knowledge and skill on their sphere of practice, and 13.4% said they were *dissatisfied,* as shown in Table 67 (below).

Table 67 Midwives' Comparative Satisfaction with Their Present Level of Knowledge and Skills.

	EP5		NEP5		Interview	
RATING	f	%	f	%	f	%
Missed Response	40	4.6	343	39.7	2	2.8
Dissatisfied	21	2.4	116	13.4	0	0.0
Little Satisfaction	85	9.6	158	18.3	4	7.5
Mostly Satisfied	495	56.1	207	24.0	20	37.7
Well Satisfied	211	23.9	34	3.9	22	41.5
Highly Satisfied	30	3.4	6	0.7	5	9.4

Midwives comments indicated that their perceptions of the adequacy of their knowledge and skills to practise midwifery often guided their employment decisions. For example, the following comments are from midwives currently registered to practise. These however, were employed in general nursing because of lack of opportunity to maintain their required level of knowledge and skill:

> *Midwifery training done in 1974 but no positions available to consolidate skills. ... Have practised in general nursing positions continuously but never midwifery. I would definitely need a refresher course before working in this area.*
>
> *I undertook a refresher course for general nursing in 1990. I would have liked to have updated my midwifery skills but there were no refresher courses available. Although I have not practised midwifery for 11 years I have retained my practising certificate by paying my fees. I feel this is an anomaly that should be investigated.*
>
> *I am mostly satisfied with my current level of knowledge and skills as I am not using these skills at the moment and would undertake a refresher prior to use.*

Midwives frequently referred to the effect of *lack of rotation* throughout practice areas. This was seen as affecting their satisfaction with their knowledge and skills to practise to their full potential. The following comments were made:

> *Knowledge and skills are well utilised but as not given the opportunity to assist during intrapartum care, these skills need refreshing.*
>
> *Such ideals will only be reached if staff rotate through all the areas of midwifery care. Otherwise skills and knowledge quickly diminish.*

The effect of specialisation within midwifery practice was also considered a factor affecting the potential to fulfil the holistic midwifery role. These examples quoted illustrate the effect of specialisation on basic midwifery skills.

> *Changed hospitals from working in neonatal intensive care for several years - now having to review basic skills as an all round midwife.*
>
> *I regard myself as a community nurse with previous midwifery experience, not as a midwife. My clinical skills have been neglected!*

6.11.8 Midwives' satisfaction with the recognition of their knowledge and skills by the nursing profession (including midwives).

Midwives expressed a low level of dissatisfaction with the recognition of their practice by the nursing profession. There were 219 (12.5%) who said they had *little satisfaction,* while 45 (2.6%) were *dissatisfied.* 771 (44%) were *mostly satisfied,* 299 (17%) *well satisfied* and 32 (1.8%) *highly satisfied.* Although the overall ratings showed midwives were satisfied with the recognition of their knowledge and skills by the nursing profession, there was a significant difference between the EP5 midwives and the NEP5 midwives (Crosstabs procedure X^2 25.143 DF 6 p .00032). Midwives not employed in midwifery during the past five years were more likely to be dissatisfied with the effect of the level of recognition by the nursing profession on their ability to practise according to the international definition of a midwife.

As only a few comments were included in the open sections on midwives' views of the effect of recognition of midwives' knowledge and skills on their potential to practise to the full potential of the internationally defined sphere of practice no trends were identified.

6.11.9 Midwives as consumers

The survey questionnaire sent to the randomly selected sample of 3860 midwives as part of this present study included a question asking midwife consumers their ratings on the care they received from their midwifery colleagues. Of the 2102 responses received, 691 midwives indicated that they had been a childbearing woman in the past 12 months, or they had been closely involved as a support person (in a lay capacity). Of these, 215 had given birth during the past year and 476 indicated they had been closely involved as a support person.

In addition to answering the question asking for their ratings on certain aspects of midwifery care (p.69) comments were included. The findings provided an overview of how midwife consumers saw their own practice through the actions/interactions of their midwifery colleagues. Questions were asked regarding the six most frequently recurring consumer concerns identified in consumer satisfaction studies *i.e. information given by midwives; support given by midwives; care given by midwives; competence of midwives; interpersonal skills of midwives; and availability of midwives.*

In reply to the invitation to rate their satisfaction on information received from midwives 344 (49.8%) said they were satisfied, however, 271 (39.2%) said they thought information giving by midwives needed to be improved. The comments made by midwife consumers confirmed the impact on consumers of lack of information of the availability of midwifery care within choices of service delivery, and conflicting advice given by midwives. These aspects demonstrating limiting actions/interactions are illustrated in these few excerpts from the comments:

> *I have two main criticisms - midwives giving conflicting advice and midwives pushing a particular barrow, especially breast feeding and failing to listen to and support the real needs and wishes of the mother.*

And:

> *Lack of information re choices and availability of midwifery care.*

Positive statements were made and satisfaction expressed with information received, as in the following comment:

> *My midwife was able to interpret the events and therefore help me understand and debrief. This debriefing was assisted by being able to read my hospital notes - the understanding and freedom from guilt liberated me properly and allowed me to enjoyably parent my delightful child.*

Satisfaction with the support given by midwives was expressed by 64.4% (424) while 28.8% (199) felt it needed improving. The dominant theme with lack of support was the perception that being a midwife affected the support given. This comment reflects the expressed concerns:

> *Being a midwife and having the knowledge was more of a hindrance whilst in hospital as an obstetric patient. I found the midwives stayed away from me as they presumed I knew all about it. I can't blame them - I would probably assume the same as a working midwife. But it is different as a patient, and I needed help like any other patient.*

Satisfaction with their care was expressed by 65.1% while 26% stated they felt it needed improving. Comments ranged from being very pleased with the standard of care

received, to expressions of the concerns expressed in all consumer reports and surveys. For example:

> *I was a Caesarean birth and was expected to care for my baby 9 hours after she was born. I climbed out of bed that many times to attend her that my wound was bleeding. I was a private patient but was advised that all patients have a 24 hour rooming in, which means minimal staff assistance even though I had abdominal surgery. Why are some midwives lacking in empathy?*

And:

> *I found the staff to be uncaring, apathetic and lacking basic knowledge in childbirth and breastfeeding.*

Throughout the comments made on care received the overriding theme was the variability in the standards of care given by midwives. This remark puts it in a nutshell:

> *Some midwives were very good and others left a lot to be desired.*

Another commonly recurring theme was the satisfaction expressed by all the midwife consumers who had received care at a birth centre. This support person states:

> *I was a support person for a friend who gave birth as a public patient in a large public hospital in Melbourne. The care, guidance and support of the midwives was excellent and the level of intervention was zero.*

The competence rating given by consumer midwives for their colleagues received the lowest dissatisfaction rating with 161, i.e. 23.3% who felt competencies needed to be improved while 456 (66%) said they were satisfied with the competence of the midwives. The knowledge base was linked to the perceptions of competence, for instance:

> *The clinical skills were good but they just did not know enough. The midwives knew very little about ABO incompatibility, telling my friend much that was wrong, upsetting and misleading.*

As found in other consumer reports there was a high level of dissatisfaction with the interpersonal skills of midwives, with 288 (38.8%) stating there was a need for improvement. There were 353 (51.1%) who expressed their satisfaction with midwives' interpersonal skills.

Comments made by the midwife consumers reflected the image portrayed through the repeated themes of other consumer studies. This satisfied midwife consumer expressed her appreciation of sensitive midwifery practice by comparing the attributes that had displeased her during a previous experience.

> *Very sensitive midwife. By her assessment she gave me encouragement and reassurance to my husband when needed and left him to take care of me, making suggestions and giving encouragement through him, so it was very much our labour, a private happy time, whereas my experience prior to this had tended to be leadership, direct hands on and imposing. I learnt a lot of different styles from my colleague, equally satisfying and attentive but far more supportive.*

Another midwife gave a long summary of her impressions of interpersonal relationships amongst maternity care providers. She described the impact division in the provision of care can have on childbearing women and their families.

> *The care given was generally excellent, but the fact that the delivery suite and the postnatal wards were staffed by completely different teams meant that my care seemed compartmentalised* (description given of experience). *Obstetricians and other doctors are not usually available to help women and their partners understand their labour and their mutual reactions to it. The midwife plays a vital, if informal, role in facilitating debriefing; debriefing which is often very important in marital and family understanding, and therefore the baby's ability to thrive.*

Another midwife spoke of her appreciation of normal conversation from midwives, while stating that:

this was not in any way a requirement of a midwife, but like the medical profession, those you feel comfortable with are the ones you can talk to.

The intensity of the impact poor interpersonal skills can have on childbearing women was strongly stated by this midwife:

Conversations with several friends who have had postnatal depression suggest that women who feel unaccepted and disenfranchised during their labours (or those who have a fragmented, confused and undignified memory of it) are more at risk for PND than women who have more tragic outcomes e.g. infant death.

Midwife consumers rated the lack of availability of the midwives' services as the major area needing improvement. Responses from 288 midwives (41.7%) stated that in their experience the availability of midwives needed improving and 322 (46.6%) said they had been satisfied with the midwives availability throughout their experiences as a consumer.

Comments focused on staffing issues, the busyness of midwives, the restrictions placed on midwives, and the lack of choice regarding midwifery care. The following excerpts demonstrate the diversity of the responses:

I requested to be delivered by midwives - the midwives and obstetricians were unwilling to comply.

And:

Every woman deserves care on a basis which does not seem possible in Australian public hospitals.

And:

Not enough staff to cope with number of patients. Help from families and friends essential due to this while in hospital.

The concepts of continuity of care and choices of midwifery models of care were linked to the theme of availability. Even as midwives there was acknowledgment that the known choices were not readily available, as stated by this midwife.

I gave birth at a family birth centre. The midwives there were great - gave good support and all the rest. I'm very worried now that I have moved to the country what will happen for number 3 child. There just aren't any choices.

Summary

The qualitative findings presented in this chapter provide some understanding of the factors midwives participating in the survey questionnaire identified as limiting their opportunities to practise to the full potential of the International Definition of a Midwife (WHO, 1976). Numerical and textual data identified midwives' ratings of the importance of facilitators and barriers to their enactment of the full potential role of the Australian midwife, based on the internationally defined sphere of practice contained within the *Standards for the Practice of Midwifery*, (1989).

The findings indicate an ambivalence amongst midwives towards the full sphere of practice of the midwife and the *Standards for the Practice of Midwifery*. While the eight identified barriers to practise were all rated as requiring important or essential changes to allow midwives to meet the *Standards* the majority of midwives were mostly satisfied with the effect of these factors on their own practice. In the following chapter these conflicting findings based on descriptive numerical data are integrated with the qualitative data from interviews with midwives, contributing to the development of a conceptual paradigm explaining the interrelated factors influencing the Australian Midwives' practice domain.

CHAPTER SEVEN

A CONCEPTUAL PARADIGM

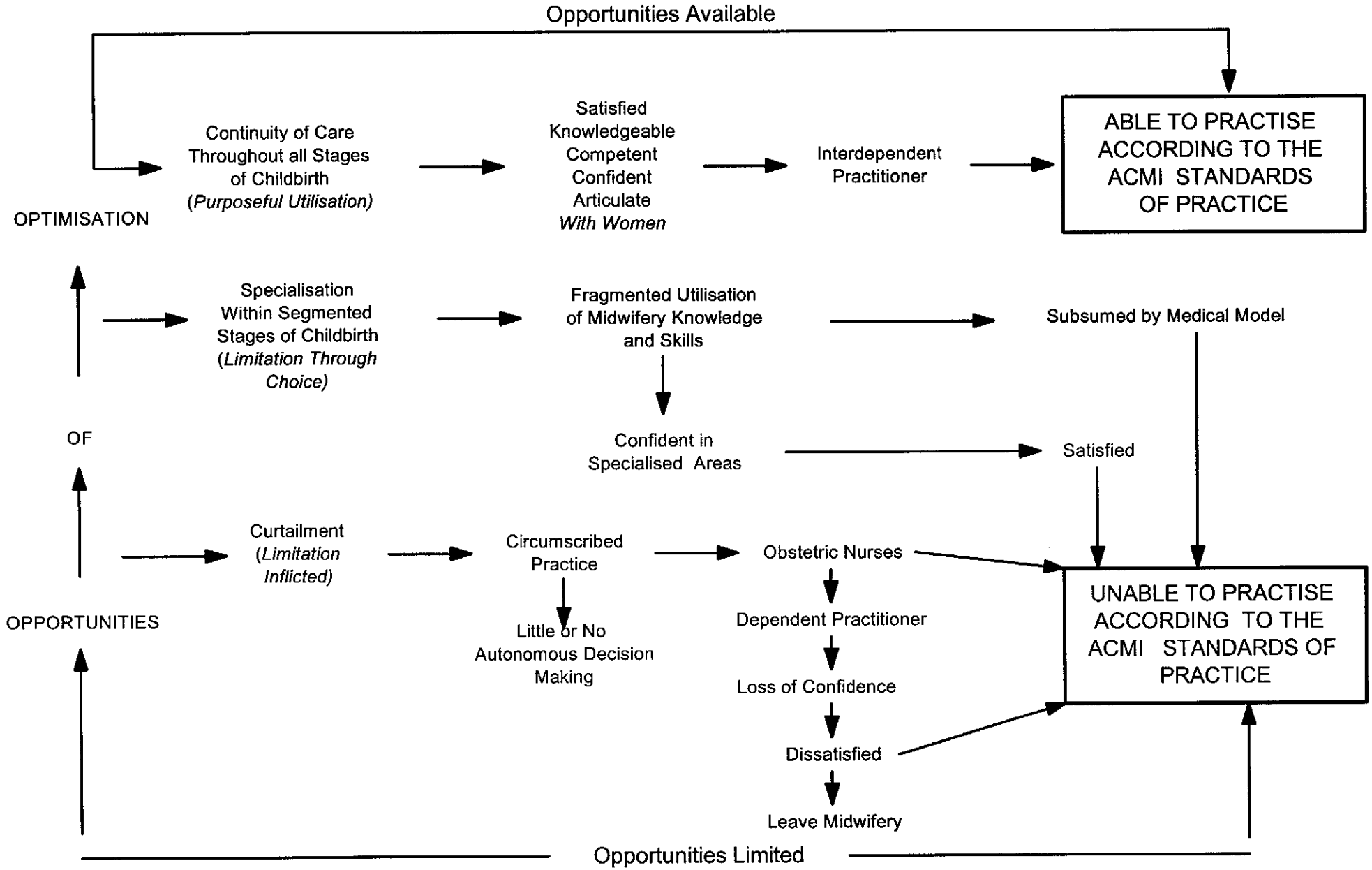
7.1 Introduction

The findings presented in Chapters Four, Five and Six are the responses given by the randomly selected sample of midwives (n=1754) who participated in the survey questionnaire. The descriptive findings in Chapter Four have identified what midwives do in their practice settings and within various models of care. Chapter Five has evaluated midwives' actions against the *Standards for the Practice of Midwifery* (ACMI, 1989) based on the *Definition of a Midwife* (WHO, 1976). The factors stated by midwives that affected their ability to practise to the full extent of the sphere of practice have been described in Chapter Six.

This chapter analyses the rich descriptive data from in-depth interviews and fieldwork to develop a conceptual paradigm of Australian midwifery practice (Schema 1 p. 198). The paradigm portrays the analysis of the complex inter-related factors that affected the midwife's ability to practise to the full extent of the accepted WHO practice definition, within the context of the practice settings.

7.2 The Conceptual Paradigm

Schema One depicts the conceptual paradigm developed around a *Story Line* that focuses on the *Core Category* that emerged from the interview data. The core category was identified as: *Opportunities for Practice Throughout All Stages of Childbirth.* This included opportunities to practise to the full extent of the WHO definition of midwifery practice which includes antenatal, intrapartum and postnatal care. Comparisons of incident with incident, setting with setting, action and interactions, demonstrated the limited opportunities available for providing care throughout all stages of childbirth, and the consequences that this had on the ability of midwives to meet the ACMI *Standards for the Practice of Midwifery* (derived from the WHO definition). Midwifery practice opportunities throughout all stages of childbirth are represented in the schema as a forked pathway of opportunities limited, and opportunities available. The former



Schema 1 Opportunities For Practice Throughout All Stages of Childbirth

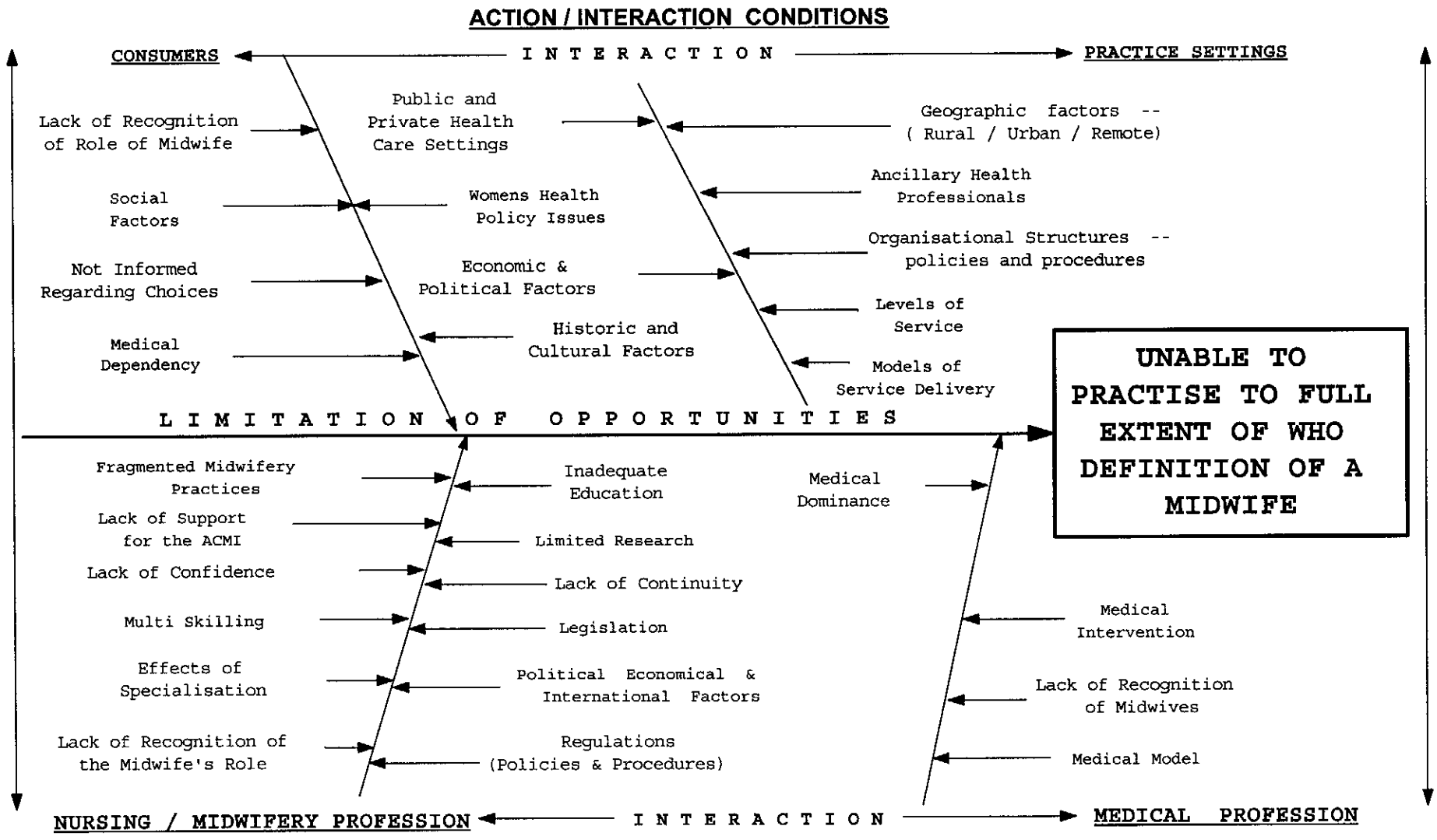
pathway is further divided into two as the limitation of opportunities occurred through choice or through infliction.

Limitation by self choice occurred in practice settings where midwives could increase the availability of their opportunities to practise throughout all stages of childbirth through optimisation, but refrained from doing so. These midwives chose to work in segmented stages of childbirth. They were often very confident in their chosen specialty areas. Although the utilisation of their midwifery knowledge and skills was fragmented, and their practice was subsumed by the medical model, these midwives generally expressed satisfaction with their practice opportunities, within their chosen specialisation. They were, however, unable to meet the ACMI's Standards for the Practice of Midwifery (1989), based on the WHO Definition of a Midwife (1976). Limitation of practice opportunities throughout all stages of childbirth was considered inflicted when contextual conditions stifled midwives' desired practice attempts. These contextual conditions affecting the actions and interactions of midwives are illustrated in Schema 2 (p. 200) under the contributing sub-titles of: consumers; practice settings; the medical profession; and the nursing/midwifery professions. The impact of these contextual conditions on the Australian midwives' practice domain is explained as Chapter Seven proceeds.

The process of optimisation is presented in Schema 1 as a continuum extending through the forked pathway of opportunities limited to opportunities available. Optimisation of opportunities was the core process affecting the ability of midwives to practise throughout all stages of childbirth.

Optimisation of opportunities to practise throughout antenatal, intrapartum and postnatal areas, involved midwives demonstrating specific, purposeful actions and interactions with health care professionals, and the childbearing women and their families, within the practice settings. An analysis of the optimising behaviours and their properties and dimensions is defined within the four contextual sub-categories of *consumer awareness, practice settings, medical subsumption,* and *nursing/midwifery integration.* These are linked to the *Core Category, Opportunities for Practice Throughout all Stages of Childbirth.*

Actions/interactions taken by midwives to optimise their opportunities to practise throughout all stages of childbirth resulted in specific consequences. The pathway



Schema 2

Contextual Conditions Limiting Midwives' Opportunities
To Practise According To The WHO Definition Of A Midwife.

depicted in Schema 1 as *opportunities available*, demonstrates the consequences of optimisation. Midwives were interdependent practitioners, providing continuity of care throughout pregnancy and childbirth. The holistic utilisation of their midwifery knowledge and skills resulted in midwives being satisfied, knowledgeable, confident, articulate, and *with women*. These consequences, in turn, became conditions affecting midwives' abilities for future optimisation of practice opportunities, thus creating an ongoing cycle towards the full sphere of midwifery practice (Schema 3 p.266). Conversely, the forked pathway of limited opportunities depicted in Schema I as limitation inflicted, led to curtailment of practice. There was little or no autonomous decision making. Midwives practised circumscriptly, fulfilling the role of obstetric nurses. This dependent practice contributed to a loss of confidence and subsequent dissatisfaction with midwifery. Where midwives had chosen not to optimise their opportunities to practise throughout all stages of pregnancy and childbirth, they demonstrated fragmented knowledge and skills, but were often confident within their segmented areas of practice. This group of midwives represented the greater proportion of midwives. They were also generally satisfied with the effect of fragmentation on their practice within the medical model.

Within settings where contextual conditions inflicted limitation of opportunities to practise throughout all stages of childbirth, midwives were provided with little or no opportunity for autonomous decision making. They demonstrated behaviours of dissatisfaction and discontent. More importantly they felt a decreased confidence to practise according to the *Standards for the Practice of Midwifery* (1989). This resulted in an exodus from midwifery.

The contextual conditions (Schema 2 p.200) affecting optimisation or limitation of opportunities to practise throughout all stages of childbirth were categorised within *practice settings, community awareness, nursing/midwifery integration, and medical subsumption.* Each of these major categories contributing to the *Core Category* is explained in this chapter, and substantiated with data from the practising midwives.

The four stages in the process of optimisation of opportunities occurring within the contextual conditions were identified as *revealing the image; influencing decision making; changing the paradigm;* and *expanding the profession.* The actions and interactions of midwives within these four stages of optimising are described as they

occurred within practice settings with consumers and health professionals (Table 68 pp. 268-269).

7.3 Practice settings

As depicted in Schema 2 (p. 200) sub categories identified within the context of practice settings affecting midwives' opportunities to practise throughout all stages of childbirth included *geographic factors, public and private maternity services, levels of service and organisational structures,* and *models of service delivery.* These are further explained in the following sub-sections.

7.3.1 Geographic factors

Throughout the field work visits to practice settings within New South Wales, Victoria and Western Australia, the impact of the diverse geographic settings on the midwives' opportunities to practise throughout all stages of childbirth was evident. Midwives described their practice settings as *remote, country, or metropolitan.* Optimising actions and interactions, within geographic constraints, were taken by midwives to varying extent within these practice settings. Excerpts from the interviews are included to illustrate how midwives in the different settings contended with limiting conditions that prevented them from meeting the ACMI *Standards for the Practice of Midwifery,* and practising to the full extent of the international definition of a midwife and the sphere of practice (WHO, 1976). Failure to practise according to the standards was synonymous with curtailment of the midwife's sphere of practice within the various practice settings..

7.3.1.1 Remote areas

Geographic areas described by midwives as being *isolated and remote* included outlying communities, nursing posts and large agricultural stations visited and serviced from a regional or district base hospital. Travelling times were described as being *several hours by vehicle* or so much *flying time* by the Royal Flying Doctor Service (RFDS) or the Aboriginal Medical Service (AMS). The effect of distance from the closest medical assistance, on the midwives' opportunities to practise throughout all stages of childbirth, was limiting. These midwives were able to provide antenatal care in liaison with the

RFDS and the AMS but were unable to care for women during labour or the early postnatal period. Care during the puerperium and early child care was also provided in community settings by carers who were not always a midwife.

The numerous factors affecting the availability of practice opportunities in these isolated and remote areas are highlighted in the following extracts from the midwives interviewed in these geographic settings. A community midwife speaking of her work in the Far West Health Service in New South Wales stated:

> *Although I had worked in country clinics before I had never been out west and I found it a very different ball game - very challenging and different. It's such a massive area and the population is so widely dispersed.*

The service was described as spanning an area of about 140,000 square miles and supporting a population of 28,166 people. As the consultant community midwife she had to set up a community midwife project. This was a response by the government to the recommendations of the Shearman Report (1989) that aimed at addressing problems in existing services. The role of the midwife as a primary health care provider was emphasised, as was the need for increased flexibility in the provision of antenatal care and culturally appropriate support for women and their families at risk. By the same token, in the final analysis, care was fragmented in terms of meeting the ACMI standards. It was evident from the comments quoted below that midwives' opportunities to utilise their knowledge and skills were limited by medical practitioners who failed to work collaboratively in the provision of best service to the women and their families. This applied where general medical practitioners based in small towns tended not to utilise the community midwife in shared care of women in remote areas. The following excerpt illustrates *inflicted limitation of opportunities* on midwives to provide shared care.

> *Antenatal care is still basically the role of the doctors throughout the region. The education is provided by midwives in a shared working arrangement with the doctors. There is still a lot of reservation about involving the midwives in the antenatal area. We have found that if we were utilised more we would be able to address more of the issues. We are encouraging the doctors to utilise the community midwives more in*

the antenatal care of the women. Now the community midwives have been on board for 12 months we are getting a lot of self referrals and family referrals. W---- is the only area that is providing a midwives' clinic as such. Other community midwives are starting shared antenatal clinics with the doctors. We are gradually getting the message across to involve the midwives in that clinical assessment and care. Many of the doctors still don't see what we are about despite education to them, so I guess we just need to continue with that.

Pregnant women living in these isolated remote areas required a very different service from midwives than those in more populated areas. Some of these different needs are described by another community midwife.

85% of my workload was generated through the Aboriginal Medical Service. The community midwife takes up anything the medical team asks her to follow up, as well as women who self refer. They would come to the antenatal classes at night and keep visiting me after they had their babies. I was living in that community and travelling out to other isolated communities... I was able to build up a strong relationship with the girls who attended the midwives' clinic I had set up. About 80% would attend but there were always those who would only turn up when the baby was due. The ones I had a lot of postnatal contact with were the ones with syphilis and other STDs... This area has the highest per capita syphilis rate for New South Wales, highest infant mortality rate and highest non attendance rate at antenatal clinics, so it is an incredibly problematic area. So those are the big things we have to try and turn around - I mean they are life and death stuff really. Like I mean the services that were in the area just weren't working. It wasn't as if they were under serviced - it needed a focus to change things. Health workers are being trained now to be able to work out in the communities. Visiting health workers aren't able to develop relationships that are needed to change what is happening. These people have to get to trust you and they want to be talking to the same person. There are lots and lots of issues and glaring needs that need to

be addressed that the services that were there have not addressed. Long term changes are needed. I've become very involved in sexuality education including all the family and school children.

Within such a working environment the midwife was side tracked from practising according to the ACMI standards. Opportunities to practise throughout all stages of childbirth were curtailed through the more pressing need to attend to problematic areas of concern. Compounding this problem, was the shifting of the obstetrician's responsibility into the domain of midwifery practice. The following quote reflects the responsibility that midwives felt working in isolation from other health professionals. Such shifting of responsibility contributed to inflicted limitation of opportunities to practise throughout all stages of childbirth.

It was an incredible responsibility especially with these very high risk women and obstetricians in Dubbo 3 hours away. They never used to come up and do clinics, and trying to get the women to go down to Dubbo was extremely difficult. I had to give all the antenatal care and I felt for these high risk women this was wrong. I mean surely one obstetrician could come up ... these were women with incredible problems. I wondered where the focus was. The obstetricians would get annoyed that the women would not come down for clinics but to do so they would have to leave at five thirty in the morning and travel on the back of a van. I mean when you're 35 - 36 weeks pregnant, or even 28 weeks in a little van shaking your way down to Dubbo to have an appointment at nine o'clock, and you knew you were going to have an ultrasound so you had to have a full bladder (laughter), and then they get angry because the girls won't go - and they would have to sit in the waiting room - they knew their English wasn't any good, and they'd want to go off and do other things. I tried to build bridges and mend bridges and you end up trying to be all things to all people. And then the other part with friction between the hospital and the AMS - it was just an incredibly abrasive situation.

Midwives working in isolated settings found limited intrapartum care opportunities. In most situations the women were transferred to hospitals at 36 weeks to await the birth

of their baby. This put a halt to continuity of care and can be seen as an inflicted limitation as portrayed in Schema 1 (p.198). Any desire by the midwife to meet the ACMI standards depended upon the hospital to which the woman was transferred. This is demonstrated by the following comments:

> *It was sad. I never had that clinical relationship with the hospital to be able to be with these women during their deliveries.*

In contrast another community midwife working out from ------- District Hospital in Western Australia had been made very welcome and was considered a member of the hospital staff. She spoke of the advantages of the contact between the remote communities and the hospital which allowed continuity of care, thus moving towards optimisation.

> *This continuity of care is such an important and beautiful concept. It's such an incredible experience to be able to develop a relationship and go right through - every stage of the pregnancy and then to be there for the labour. It's almost in a way like looking after one of your friends. We are in a wonderful position here where we know the women, we've looked after them throughout their pregnancy, and if we are fortunate enough to have them labour and deliver here (because there is still political pressure to transfer them out to the regional hospital because of our isolation), then if they do labour in town the whole town knows and everyone is interested and involved.*

The transferring of women to hospitals at 36 weeks gestation not only deprived the women and their families of continuity of care, it also inflicted limited opportunities for holistic practice on the midwives. It posed a barrier to optimisation through limiting the midwives' opportunities to maintain their skills and confidence in providing intrapartum care. This was an important issue in all the smaller remote area hospitals where policies stated that women should be transferred to the larger regional hospitals where there was usually an obstetrician on the medical staff.

The effect of transfer policies for remote district hospitals on the midwives' opportunities to practise throughout all stages of childbirth, as well as on the women and their families, is demonstrated in this short case study from the --------- hospital.

Basically women in the past were "punished" for having babies here. There was an awful attitude - you can see it in their records - ... midwives and doctors were involved - it was one of those things that was done, it was a sacred cow that's been here for years and years. And women still quote that to you - "but I'll be sent away, I'll be sent away". And we are still placed in a situation where women will be sent away if at the time that they come in in labour we still have policies that say that if the woman is less than four centimetres dilated, and if we don't have a midwife available and a doctor who is prepared to cover them, then they still have to go.

We had a situation here a little while ago with exactly that situation. Primigravida, who came in at 37 weeks, labouring, and the decision made at the time by the doctor, because he gets the final say, was that he had no obstetric experience and this woman had to go. So everyone got hypertensive about it and we said "well let's get on with it and do it - we'll do our midwifery stuff and we'll just see what happens", and of course we knew she was 3-4 cms and she had just cracked on, so we knew she would deliver before the RFDS got here, but that was out of our hands and we just got on. We did all the paper work, got on with looking after the lady, just beautiful, fantastic! and everyone kept having 10 cents worth about whether the RFDS should come. And we said "look, it's not our decision, the RFDS is coming, but if she is more than 4 cms she can't get on the plane until she's had her baby". That's the ruling that goes, that if its uncomplicated they won't put them on the plane greater than 4 cms, they have to deliver here, and if the RFDS did come and she had had her baby she would then be assessed if she was medically fit to stay here and she wouldn't be going to ------- if she was medically fit and her baby (sic). While all this was going on we got on with looking after the lady, and we had a beautiful delivery 10 minutes before the RFDS arrived, so I waited 10 minutes just to check she wasn't going to bleed or go flat on us, and I rang them in the air and said "these are the circumstances ... you make your choice whether you're

going to land or not". They spoke to ------ in ------ who said there was no reason to pick her up, so they turned around and went back. So it saved them money in the long run , but the whole point is you could say what a waste of money. Those are the laws that are still laid down and we abide by them and everyone else has to make their decisions. We tell them what we're doing and they make their own decisions around us - And it was beautiful - great delivery - great for the woman. It was best care for the woman and she ended up staying here with her baby and her husband, and it was wonderful.

This midwife went on to say that historically 25% of the women in the area have ended up having their babies at the --------- hospital because:

they have voted with their feet and would turn up in late labour. Consequently, because they were given such appalling treatment the women didn't get early pregnancy care so they wouldn't come in to hospital. They would front up for their first antenatal visit when they were crowning and - well you know- they were making sure they wouldn't be sent away - so they wouldn't come in for antenatal care. That's changed! That's changed brilliantly! We've got so many women on our books coming for antenatal care now - it's brilliant!

The change in the attitude and behaviour of the women was attributed to changes in both midwives' and medical officers' *attitudes towards women and this punitive punishment of the women.* A collegiate working relationship between the incumbent Medical Officer, the Director of Nursing, the hospital midwives and the community midwife was the catalyst for change which allowed midwives to optimise opportunities.

Another example of inflicted limitation of opportunities to practise throughout all stages of childbirth was the substitution of skilled midwives by remote area nurses or midwives lacking the specific knowledge and skills required in remote areas. Where midwives lacked the knowledge and skills to practise according to the sphere of practice defined in the ACMI Standards for the Practice of Midwifery they were unable to meet either the standards or the needs of the women living in these remote settings. This was emphasised by a midwife at the ------- Regional Hospital;

It is a concern that women coming in from remote areas may not have received optimal antenatal care as remote area nurses are not always midwives. Even midwives working in these areas need specific knowledge and skills to meet the needs of the women and their families in these settings. Cultural sensitivity and appropriate interpersonal skills are just as important as the clinical expertise.

7.3.1.2 Remote Regional Hospitals

Midwives working in Regional Hospitals or District Base Hospitals that provided obstetric services in the remote areas, expressed a high level of satisfaction with their opportunities to practise throughout all stages of childbirth. With the transfer of women to the regional hospitals at 36 weeks gestation they were able to provide some antenatal care and education. There was also the opportunity to provide care to the same women throughout labour and the immediate postpartum period. In many instances the women and their babies would be transferred back to the smaller country hospital or be discharged under the care of the area's Child Health Nurse.

A practising midwife, based at the Kalgoorlie Regional Hospital servicing the Northern Goldfields and Central region of Western Australia, expressed enthusiasm and excitement in the optimisation of opportunities, with purposeful utilisation throughout all stages of childbirth. There was an expression of satisfaction as portrayed below:

I would say that I would get over 50 deliveries a year. We have 20 maternity beds, 3 delivery rooms, 1 prep room, 2 nurseries and the antenatal clinic. We all take it in turns. It's just all up to you. You may have a busy week doing labour ward so you might change with someone and do the postnatal ward. All the midwives like labour ward but if you've had too much of it you can change. Everyone has their fair share - it's up to you really. Like it is all one unit, its not on different floors or anything.

... Like - Kalgoorlie is the ideal situation if you have to work in Australia and it would be very difficult to leave it. It would be like going back two paces - although I'm told Derby is also a very enthusiastic unit.

While the difficulty of recruiting and retaining midwives in remote areas was a concern expressed by midwives in these settings there was also a concern expressed of the difficulties in attracting obstetricians. Midwives were quick to acknowledge their dependence on the obstetrician for high risk women and emergency situations where both the mother and baby could be in danger. The concern for the Kimberley region was clearly stated by a midwife at Derby Regional Hospital who was conducting a review into the obstetric services for the Kimberley region.

> *The concern is that we can't get an obstetrician here. This is what has initiated this project to look into the services throughout the Kimberley - the concern that we can't get an obstetrician here - I mean there are other concerns as well from a midwife's perspective but concerns are that we are not providing the best service to the Kimberley and while the majority of our deliveries are midwife deliveries, we still need the back up of having skilled medical officers or an obstetrician here - to give us the back up as well. The concern is why do women get sent here if we don't have the medical skills here?*

The optimisation of practice opportunities by midwives in the remote areas was affected by interactions between health professionals, and the women and their families. Where collegiate relationships existed between midwives and medical practitioners, within a supportive administrative environment, multifaceted practice opportunities were optimised. As a result these midwives demonstrated both confidence and competence in their practice. This was seen in the manner in which the midwives were articulate as consumer advocates, promoting empowerment of women by helping them to make informed choices regarding their pregnancy and childbirth care. The core consequence of these optimising interactions was that midwives were able to practise to the full extent of the WHO *Definition of a Midwife* (1976).

7.3.1.3 Country areas

Country areas were described by midwives as those being within several hours travelling time from a city or large town. Midwives spoke of country hospitals as those based in towns which serviced populations of scattering smaller towns. Such towns were usually supported by mining or agricultural industries. These areas often bordered on those

described as remote, but were interchangeably referred to as country hospitals by the midwives. Country hospitals differed greatly in size and also in the range of services that were offered. District and regional hospitals often served both country and remote areas.

The effect of country settings on the midwives' *opportunities to practise throughout all stages of childbirth* was again interwoven with the interactions between the *practice setting; the medical profession; nursing and midwifery professions; and the consumers.* Geographic factors affecting opportunities to practise are demonstrated here through excerpts from midwives interviewed in country settings throughout New South Wales, Victoria and Western Australia.

Midwives' opportunities to practise throughout all stages of pregnancy and childbirth within these country settings were most strongly influenced by the medical structures of the hospitals. While regional hospitals servicing remote areas were mainly staffed by medical officers employed by the Regional Health Services, country hospitals were more often serviced by general practitioners who had private practices in the country towns. Larger hospitals also utilised the services of specialist obstetricians in private practice, while hospitals servicing a large region, in some instances, employed an obstetrician.

The link between geographic settings and the availability of general practitioner/obstetricians and specialist obstetricians was evident from the interviews with midwives in country and remote settings. The effect of the availability of medical staff (qualified in obstetrics) on the midwives' practice opportunities, was also interwoven in the interview data.

A group of midwives at the Geraldton Regional Hospital servicing the Mid-west Gascoyne Health Region in Western Australia spoke of the difficulty experienced in recruiting an obstetrician to this area.

> *We are expecting our first obstetrician this month supposedly, but she's been coming for about 12 months now. But it works quite well without you know. If there are any problems they get sent to Perth - the general surgeons here do the Caesars. There are 3 of them and they do the Caesars . It works out all right. Any high risk patient gets pretty smartly sent off to Perth because we don't have a paediatrician in town*

either. We average 36 deliveries a month at this hospital ... Our town is staffed by GPs - we don't have resident medical staff. There are a lot of them, about 15. Most of them are reasonably happy just to be called for the delivery. They don't mind if they miss the delivery so long as they're there round about that time, however, there are several who don't like it and we try to fine tune it. Some do a lot more mids (sic) than others and some are more confident and competent than others. ... The GPs have got this town sewn up though. If they don't want a paediatrician or obstetrician here they just don't refer. We had a paediatrician years ago but he didn't last long for this reason. So it's very difficult. ... The community just take it as routine that they travel to Perth for specialist treatment. Financially they get assisted through PATS (patient assisted travel scheme).

The presence of general practitioners in a country town curtailed midwifery practice. This was an example of inflicted limitation on opportunities for midwives to practise throughout all stages of pregnancy and childbirth. This was particularly evident during the antenatal period. Midwives were seldom involved in providing clinical antenatal care and only had contact with the women through antenatal education classes, or for a brief interview when the women came to the hospital to *book in*. Most often the first contact that midwives had with women would be when they arrived at the hospital in various stages of labour. This was seen as detrimental to the care of the women because of the discontinuity of care. Midwives felt that they were not given the opportunity to develop a supporting relationship with the women and their families. This was further exacerbated by the non availability of medical records on the health status of the pregnant women. The following short excerpt from a midwife practising in a country hospital in Victoria illustrates this viewpoint:

The set up with our patients is that they don't come through an antenatal clinic in this hospital. They actually go to their private practitioner who looks after them for the whole of their pregnancy. We see them for their antenatal education and booking in and when they come in - in labour. So we have very little input into what they go through before they get to hospital.

This same midwife spoke of a pilot project in which she had been involved, where she had the opportunity to see the women for one antenatal visit at 32 weeks gestation. The project, however, was discontinued due to lack of funding. Although the contact was minimal she spoke of the advantages this project had for the women and midwives.

> *I was staggered at how much I found out about the women that we knew nothing of, and it gave them some continuity. Many of them had great concerns about how they would cope in labour - "I'm really frightened - I had this problem last time - I hope it won't happen next time". It really gave us a great rapport with the women. It was really incredible the difference it made to these women, and how I felt about them. It was a really good thing and I felt really good about it. You know - just to talk about how they were feeling, did they want to breast feed, did they have problems last time, did they overcome them and what could we do to overcome them this time?*
>
> *It was an excellent process we went through. It had been recommended by the birthing services review committee, and that was why we set it up. But the funding ... it was just something that could not be afforded anymore.*

Apart from antenatal care, midwives working in country hospitals were generally satisfied with the opportunities for continuity of care available to them. The structural layout of these smaller maternity units was such that midwives could move easily between the labour and delivery rooms, and between postnatal wards and nurseries. Midwives from large metropolitan hospitals on an interchange program with country based midwives were quoted as having enjoyed the opportunity to practise continuity of care:

> *When the girls from the Womens transferred up here, their perceptions of what it was like, how they just loved it! We take it as wrote. You get used to what you deal with, but when they realised that when they came back the next day they would have the same lady here as they had the day before, and see them here for two or three days before saying goodbye to them, they were really committed and "this was my patient" and they had a real feeling of satisfaction. I hope midwifery will*

continue in that vein in little places like this because I think larger hospitals tend to segregate both staff and the mother or the family and they don't have that ongoing care.

Midwives in country areas also spoke of their opportunities to use their midwifery knowledge and skills as *autonomous practitioners*. The following description conveys this notion:

You find out what it is like to work in a unit and not have doctors at your beck and call. To actually be a midwife and not just to have a doctor to resuscitate the baby within minutes of needing attention. To deliver a mother totally and to be resuscitating and caring for the baby as well as her at the same time. And then to have the continuity of looking after that mother afterwards ... it gives a great sense of being an individual autonomous midwife.

We have a lot of chances because we are a country unit, because we have doctors who trust us - I like to think. We do a lot of the deliveries, we do a lot of the examinations, we virtually look after the women totally. We have the doctor there probably as back up and I think that's how it should be. It gives us the sense of being worthwhile as a midwife. We are practising our art.

Autonomous practice was mitigated by the size of the maternity units in country areas. There were, therefore, limited opportunities for midwives to maintain their knowledge and skills. Country hospitals providing level one services often had a low number of deliveries. This frequently meant that midwives were required to practise as general nurses as well as midwives. There were mixed reactions from the midwives in these situations. The first excerpt is from a midwife practising in a country hospital where there were approximately 100 deliveries per year.

We transfer out a lot - any one considered at any risk is transferred out. We do rotate to the antenatal clinics so we get one or two goes a year. The doctors tend to want to see the women themselves and we get to mainly do urine testing, blood pressure and weight, thankyou. You can use your own mind though and follow up on anything you pick up. There are four doctors on the staff here and they provide all the medical

services for the town. There are no private doctors' room - everyone comes through the hospital outpatients. In the ward we do everything and outpatients as well . It's a mixed medical, surgical, paediatrics and maternity ward so we do everything. If you have one mid (sic) patient you still get half of the other patients as well. Sometimes it frustrates me because you don't get the time to talk with the mid (sic) patient - just chatting and educating. You find yourself jumping into all different sorts of roles ... instead of just having a mid (sic) area where you can get a group of mums together and have a discussion on different things. With only one midwife on, and still having to look after the rest of the ward, we keep the women in labour in the ward so we can keep an eye on everything. This gets frustrating especially when the women get closer to second stage. The staffing situation is not good. Often you are not replaced during the delivery ... .

This English midwife working in a larger country hospital felt strongly about being expected to be skilled in general nursing as well as midwifery.

After years of practising as a community midwife in London I took on this job here as a registered nurse/midwife. I was allocated the mixed medical surgical ward for three months which I was not familiar with having not done general nursing for over ten years. I was immediately considered to be multi skilled and I felt I was trying to live up to a dream that the management had - not I. I found myself mourning for my loss of contact with women, and I suppose I became quite depressed about it. When I did get moved to the obstetrics and gynae (sic) ward to me it was not midwifery - it was obstetric nursing!

Interviews with midwives in smaller country hospitals in more isolated areas showed that some enjoyed the challenge of being multi skilled although they often referred to the *cultural shock* they had experienced when first facing the responsibility of managing a labour and delivery alone. The following excerpt is from an interview with a midwife who had worked in small country hospitals in South Australia, New South Wales and Western Australia for over 30 years. At the time of the interview she was working

around country areas in Western Australia relieving permanent senior nurse/midwives in isolated country hospitals and nursing posts.

> *In the city hospitals you've got the chance to specialize if that's what you want. That's not what I've ever wanted. I prefer the smaller hospitals - and always have. You've got to have a bigger range of skills. If you're on the main road like we are here anything can walk in the door at anytime- it's amazing the amount of emergency stuff we can get here - and you've got to be able to cope otherwise there's not much point in being here. ... I was quite honest when I came here. I said I hadn't had too much mid (sic) for a long time. It's hard to get deliveries in these smaller places. Most women go to the larger centres. I said I needed a refresher to get my confidence up but I still got my registration through. I came to the conclusion they must be desperate for midwives in these remote areas. I was called in for a delivery the other night. It was great - it's like riding a bike - you don't forget how! The doctors here work for the RFDS. If they are called out on an emergency flight the hospital is left without a doctor. That's not so bad for us older ones but I feel sorry for the young girls straight out of college being left on the wards.*

Another geographic factor affecting midwives' confidence to optimise practice opportunities was the travelling distances to attend midwifery workshops, seminars and professional meetings. This was discussed by all the midwives in remote country areas. A midwife quite plainly stated her difficulty in maintaining midwifery knowledge and skills.

> *Its alright to say "look we've got seminars here and an update coming up". You can't get to them. It's b----- impossible to go 400 kms to updates and seminars. With staff being cutback and working on a tight schedule with your staff, so you can't always give the girls the extra time off they need to go to these things. To go to Geraldton from here it's not just a day they need - you just about need 3 days because of the travelling, so it's not a simple thing going to point A to point B to get some extra lectures in ... I must say there is a lot of regional cooperation*

to give us opportunities to keep up to date in our practice by going and working in the regional hospital for several weeks at a time, but this isn't always the best for your family.

The cost of travel was another factor impacting upon the maintenance of midwifery knowledge and skills. Midwives working in remote areas found that the cost of flying to the nearest city to participate in educational activities was often beyond their means. Besides, there was the question of finding a replacement even for a short period of time.

7.4 Metropolitan settings

Opportunities to practise throughout all stages of pregnancy and childbirth by midwives in the metropolitan settings were affected by organisational structures and models of care provided in different settings. The perspectives of midwives on these factors were analysed within sub-categories of *public and private health care settings; organisational structures and levels of service; and models of service delivery.*

7.4.1 Public and private health care settings

The effect of private health care on midwives' opportunities to practise their defined role was more marked in the metropolitan areas. Many of the country and remote areas were without private health care providers while metropolitan settings provided many choices. Women could choose to be confined in private hospitals, birth centres, or in their own homes. Alternatively they could be private clients within a public maternity service setting. Each of these settings had a distinct influence on the level of autonomous decision making and practice opportunity for the midwives involved. This is demonstrated in the following excerpts from the various settings:

The first extract is from a midwife practising in a public hospital in a Sydney suburb.

Eighty per cent of our patients are public clinic patients, so if they're a clinic patient we admit them. If we anticipate a problem we'll contact someone. If there's no problem it's all ours. So we have about 1700 deliveries a year say, so 80% of those are ours. And that's wonderful! So much as I'd like to work at S------- which is just down the road from where I live, they have 80% private patients so you have no say in what

the ladies are going to do. ... Between S------Shire and B------- Area there is that big a difference. Because of the large percentage of privately insured patients at S---- the community is right behind them fund raising, getting equipment etcetera, etcetera, whereas as B----- because 80% are clinic it's a high ethnic population. We have a lot of Arabic ladies, a lot of Vietnamese, a lot of unemployment,- a lower socio-economic area. There's not a lot of community support to fund raise for the hospital.

In an interview at the S----- hospital referred to above, a midwife employed in that setting spoke strongly about her perceptions of the influence of private care on the practice of midwives within that setting. The following except provides an expose of circumscribed practice that leads to functioning as an obstetric nurse rather than a midwife.

This area is a fairly affluent area in the fact that over 60% of the patients are private and less than 40% would be clinic patients - which makes a big difference in their care. There's no obstetric registrar here because the number of clinic patients is too low and there is opposition from the private obstetricians. I was employed here to work in the low risk birthing unit, but because of this opposition it hasn't been opened. You know, women here don't get choices ... I think the number of women who deliver at this hospital is dwindling because they are not given choices. Their obstetricians may say "no you can't do this" or "you must do that", so some of the women are starting to say "hey, wait a minute, this is my baby, this is my body - I'll go somewhere else where I can do what I want". But I think the connotation too is that private must be better. That's a real sort of Caucasian feeling I think. ... Although this is supposedly a public hospital the obstetricians here don't think of it as a public hospital. They treat it as their own private obstetric unit. ...The midwives or obstetric nurses or whatever you like to call them often agree with what they (obstetricians) say and they won't stand up ... . I think the midwives here are obstetrician advocates,

not patient or midwife advocates. I think they are obstetric nurses not midwives. They're just not motivated enough!

Midwives working within private metropolitan hospital settings were more accepting of the fact that they were employed by organisations whose established philosophy was to provide obstetrical care to women and their families choosing to be under the care of their private obstetrician. Although they expressed regret at not being able to function as midwives according to the WHO definition, they were satisfied with the level of responsibility they were allocated. The following short extracts from private hospital settings illustrate this:

This hospital is a private hospital. The obstetricians who send patients here have all private patients. We have been looking at this hospital becoming a training hospital for midwives but whether or not that gets off the ground will depend on whether obstetricians will agree to student midwives delivering private patients. One of the reasons women come to a private hospital is that they know they will get their own obstetrician to deliver their baby, where as if they go to a public hospital they know they will get a midwife, or a pupil midwife to deliver their baby, and that's not what these women have chosen to do. ... We could work it if we wanted to. We could call the doctor late and say "look, she gave two pushes and bingo the baby was out", but that isn't why people come to this hospital. They come here to have their doctor deliver them, so therefore it's our responsibility to try and get him here. ... We rarely get deliveries, because the longer you do midwifery the more skilled you get at getting the doctor here on time. Of course all the midwives who work in labour ward would love to get more deliveries but I do feel that the staff who work in this hospital are very satisfied. We have a stable staff - they usually only leave to have babies themselves and then they come back to work here. ... Women don't only choose their obstetrician, they choose their hospital, and our hospital has a very good name for giving excellent nursing care.

In a similar vein of acceptance of a subsumed role, a midwife coordinator of a large private hospital had this to say:

In this hospital we are very much governed by what the doctors want. In a private hospital the doctors bring in the patients and that's your bread and butter so therefore we tailor our needs to what the doctors want. And I think too in midwifery training in this hospital the midwife has always had direction and she hasn't been out there, in this hospital for instance, practising on her own. The deliveries she does are under supervision. Also the patients expect the doctor to deliver them. The patient says I've been going to this doctor for nine months and I'm paying so much money etcetera, where's my doctor. And most doctors get upset if they don't make their deliveries and patients get upset if they don't make their deliveries, and I would say doctors get upset because their patients get upset.

This midwifery coordinator went on to explain the comfort zone of the midwives at this particular hospital. They were satisfied in their role of dependent practitioners and appeared not to be disturbed with the effect that doctor control and supervision had on their practice.

I don't think the midwives in this hospital are going to suddenly demand an extended role. They are quite comfortable with the doctors making the decisions, and that's because that's the way we've been here. There are not many midwives who are actively involved in the College of Midwives because they are obviously happy the way things are.

7.4.2 Organisational structures and levels of service delivery

The levels of service delivery have been defined by the Australian College of Paediatricians (National Health Medical & Research Council, 1987), included as Appendix 8. The intent of the Australian College of Paediatricians in defining the three levels of care was to establish areas of responsibility for individual hospitals. It was recognised that all obstetric units would not have the facilities to be able to deal with certain problems. A regional system was therefore established that extended from community hospitals, offering services for uncomplicated deliveries and the care of normal neonates, to large medical centres and maternity hospitals, thus providing a comprehensive regional perinatal program. The three levels of service defined by the

Australian College of Paediatricians had a major effect on the practice opportunities of midwives within all settings throughout Australia. In remote and country areas, services were restricted to level one, with larger district or regional hospitals extending to level 2 services. Within metropolitan settings the three levels of care were available within both public and private settings. The range of service was determined through the organisational structures of each facility and the complexity of clinical, educational and research resources provided by each organisation. The effect of these levels of care was also closely intertwined with organisational structures, policies and procedures, and models of service delivery. The combined impact of these factors on the practice of midwives in metropolitan settings was evident in the interview data.

7.4.2.1 Level 1

As defined by the Australian College of Paediatricians (Appendix 8) level one services provide for uncomplicated deliveries and normal neonates. The definition (NHMRC, 1987) states that *medical supervision is usually provided by general practitioners in consultation with visiting obstetricians and paediatricians.* In such settings midwives were often able to optimise practice opportunities. Paradoxically, there were times when the increased responsibility midwives felt when working with some general practitioners caused them to step outside of the midwifery domain. This occurred where midwives lacked confidence in the general practitioner's ability to ensuring safe outcomes for mothers and babies. A midwife working in a public metropolitan hospital with approximately 1000 deliveries per year voiced her concerns as follows:

> *My main concern is with the GPs. We don't have registrars here so GPs look after their own patients and provide medical assistance to the obstetricians. Although they have a diploma in obstetrics some of them have not kept up with things. For example, what do you do with a doctor who looks at a CTG.* (cardiotocographic) *tracing upside down and then asks you "what are you worried about sis?", when what you are worried about is that the baby is in danger and something needs to be done about it quickly! Some of them will listen to what you say but you get others who will not admit they are out of their depth. Some even turn up 15 minutes after the birth very conveniently every time!*

The unpredictable availability of medical practitioners also contributed to midwives overstepping the domain of midwifery practice. In level 1 metropolitan settings the general practitioner was often the first medical contact. Referrals to specialist obstetricians , paediatricians and anaesthetists were expected to be made through the general practitioner. Midwives adhering to organisational policies and procedures were often placed in situations where they delayed the initiation of interventions while attempting to contact the general practitioner. In some of the level 1 settings midwives had prepared themselves to step in and initiate procedures that were usually performed by medical practitioners. The following excerpt from an interview with a clinical nurse specialist in a public hospital with 7-800 deliveries per annum illustrates the extended role taken on by these midwives:

> *We are a GP unit with a specialist obstetrician on call. Everything is more or less left up to the midwives here. We have a resident here but he doesn't do a great deal. I'm preparing midwives for their extended role, which includes perineal repair, scalp electrode placement, IV (intravenous cannulation), initiating IV syntocinon for inductions. When we have booked inductions coming in we admit them, examine them, rupture membranes, put their drips in - all that sort of thing. --- We have a bigger extended role than most places because we've only got people on call (medical). We can have a delivery here and the doctor who's on call for that delivery can be at ---- which is a 40 minute drive in traffic so we get on with it ourselves. If we run into a problem we fax CTG tracings through to the GP, or if we know it's an obstetrician's problem we may by pass the GP and call the obstetrician. --- We do CTGs routinely on everyone admitted to the labour ward.*

In addition to initiating and performing these obstetrical procedures in the absence of the medical practitioner, midwives in level 1 public metropolitan settings could find themselves without readily available medical assistance in emergency situations. Such a precarious position is depicted below:

> *If we get stuck here with a flat baby we may have no medical practitioner whose done any paediatrics, which leaves us to resus [sic]*

the babies. The nearest paediatrician is about 40 minutes away and he's not always available.

The variability in the availability of medical practitioners in level 1 organisations required midwives to constantly adapt their level of autonomous decision making. In non emergency situations high risk women and neonates requiring special care would be transferred to level 2 or 3 hospitals. In emergencies however, midwives had no other option but to perform life saving procedures

A source of satisfaction to midwives working in level 1 hospitals was their opportunity to practise throughout all stages of pregnancy, labour and the postnatal period. Midwives optimised their holistic practice opportunities by rotating through the practice areas, particularly in smaller settings where the labour wards and postnatal wards were in close proximity. Antenatal practice opportunities were, however, limited to educational activities for many of the midwives. In some of the level 1 settings there were special midwives' clinics that had been established for public patients who were deemed to be at low risk. These clinics reflected purposeful actions taken by midwives to optimise their opportunities to practise throughout all stages of childbirth.

A disadvantage of the smaller level 1 hospitals was the shortage of staff. In such situations midwives cared for those requiring maternity, medical and or surgical care. This mixed staffing methodology which led to decreased midwifery practice opportunities, was not as common in the metropolitan areas as in rural settings. A midwife spoke of the loss of confidence that could result from limited opportunities in smaller settings. This is what she had to say:

Being a 30 bed hospital with only 120 deliveries a year I have only had the opportunity to deliver 3 babies in the last twelve months. I find that having too much time between deliveries I loose confidence in my clinical skills and I actually find myself wanting to keep away because of this. It is very difficult to get enough practice to stay clinically competent. I don't consider myself to practise within the WHO definition of the role of a midwife, in fact my practice has little similarity to this because it is so fragmented. I work as an obstetric nurse in the maternity area and at the same time I am continuing clinical nursing in the medical/surgical wards.

The *fragmented role* mentioned in the above excerpt was referred to by midwives practising in hospital settings that provided all levels of service. Just as midwives in smaller level 1 settings found their practice fragmented, through the inclusion of general nursing with midwifery care, so also did midwives in levels 2 and 3 settings, through their specialisation in one area of maternity services.

7.4.2.2 Levels 2 and 3

The term *specialisation* has been used in this study to include any area of midwifery practice that midwives had remained in for some length of time, which tended to reduce knowledge and skills in other areas. It did not necessarily follow that these midwives were *specialists*, although in some cases, and in particular areas such as neonatal intensive care, lactation consultancy, parent education and child health nursing, this could be so. Examples of specialisation included: midwives providing antenatal education and preparation for parenthood, midwives working in antenatal clinics or antenatal hospital wards, labour and delivery wards, postnatal wards, lactation consultancy, nurseries, special care and intensive care nurseries, and midwives involved in early discharge programmes.

Specialisation in level 2 and 3 settings appeared to be a dominant factor affecting midwives' opportunities to practise throughout all stages of pregnancy, labour, and the postnatal period. Midwives spoke of practising in specific areas for long periods of time with little, or no contact with other aspects of maternity care. This is demonstrated by the comments of a midwife in specialised roles until the recent introduction of rotation through other practice areas.

> *I've been a midwife for over 10 years - and I haven't wanted to do any thing else. The majority of my expertise has been in antenatal and postnatal care, although I have always seen midwifery as everything from early conception through to after the baby goes home, so I'm really pleased now that rotation has come in at the Women (sic) and I've got this opportunity to catch up with labour ward skills. ... My ward specialises in diabetes during pregnancy and all the complications that go along with that but it's nice to think that I can come to labour ward now and look after my diabetic patients in labour with a really good*

understanding about their management antenatally. ... And there was an emergency on the antenatal ward the other day when I was working and I had to bring a very sick patient to labour ward in a hurry, so I now knew what labour ward would want. I was able to prepare the patient and because I now felt confident in the labour ward I was able to stay with that patient until she went to theatre. And I thought well maybe a few months ago I wouldn't have felt so good about that because labour ward to me was a foreign area, something I hadn't worked in for 10 years! And I could really start to see the benefits of the team midwifery approach - it made it a lot better for the patient, knowing me, and for her husband too.

Many of the comments made by midwives during the interviews indicated that the profession had recognised the impact of specialisation on the midwives' ability to practise competently within all areas of maternity care. This was particularly so in larger organisations where it had been considered more convenient to have midwives work in one area for prolonged periods of time, than to have a constant change of staff. The excerpt below is from a midwife who had worked in the postnatal wards of a large teaching hospital. It demonstrates the effect of specialisation on one aspect of maternity care in terms of a midwife's opportunity to practise in all stages of childbirth.

I have worked in the postnatal wards since I finished my training in 1986. As associate charge nurse I am considered as core staff and I don't get to rotate to other areas. With what is happening now with rotation through the areas being introduced for some of the other staff, I would certainly be very keen to get the opportunity to rotate to the labour and delivery wards and get my skills up. I would be very happy to practise midwifery being able to do everything. I have been able to rotate to antenatal clinics a few times, but as far as delivery suites, I haven't been able to rotate there.

In large level 2, and level 3 organisations midwives working in a delivery suite had often worked in that area for many years with little or no involvement in antenatal or post natal care. Their role in these settings, therefore, was recognised by other health professionals as specialised. These midwives were involved in teaching their specialised

skills to other midwives and to medical students who rotated through the delivery suite. The concept of specialisation within midwifery, and the teaching of specialised skills, is demonstrated in the following excerpt from a midwife who had worked in a large level 3 hospital's delivery suites for over 20 years.

> *In this particular field of midwifery where I am caring for women I am most privileged. I have chosen to be a delivery suite midwife and I find this most challenging. We have midwifery students, medical students who are coming through, and I very much enjoy the role of education, which is my role in delivery suite - educating student midwives, medical students, junior staff sisters to this role of midwifery...My role in teaching the medical students is to teach intrapartum skills required in delivery suite - we double scrub* (both student and midwife wear gloves and use their hands together) *to teach them the basic skills of doing a delivery.*

This midwife also referred to a *core of delivery suite midwives.* This meant that although midwives from other areas sometimes rotated through the delivery suite there was always this core of permanent, specialised *delivery suite midwives* available to propagate a continuation of accepted delivery suite practices.

The consequences of specialisation within midwifery on the opportunities for midwives to practise throughout all stages of childbirth were particularly evident throughout settings that provided the *specialist obstetrician model of service delivery.* These midwives expressed high levels of satisfaction with their specialised roles and felt that their knowledge and skills were well utilised. They readily acknowledged that they did not practise to the full extent of the WHO (1976) *Definition of a Midwife*, and that they lacked opportunities to practise throughout all stages of childbirth. This was seen as a choice to develop a specialised role and to contribute to the care of women and their families who required, or who chose, to be recipients of specialised care in any of these midwifery practice areas. Within their specialised practice areas these midwives demonstrated a high level of confidence in their knowledge and skills. In contrast, they expressed a lack of confidence in their current level of knowledge and skill, to practise throughout all stages of childbirth.

The adverse consequences of specialisation on midwives' opportunities to practise throughout all stages of childbirth had been recognised in some organisations. Models of midwifery service delivery that enhanced integrated midwifery practice had been introduced and were closely linked to the concept of continuity of care for the childbearing women.

Midwives visited and interviewed by the researcher in level 2 and 3 practice settings referred frequently to the effect *specialisation* had on the ability of midwives to practise according to the WHO definition of a midwife. While midwives were quick to acknowledge the advantages of being able to practise throughout all areas and provide care at all stages of pregnancy, labour and delivery, and postnatally, they were aware of the organisational difficulties involved because of the high risk and advanced technology prevalent at this level of service delivery. Whilst Coordinators of Clinical Nursing and Directors of Nursing spoke of their concerns about specialisation and the fragmentation of midwifery practice, they were cognisant of, and accepted that specialised knowledge and skills were required by midwives who worked with specialist obstetricians, paediatricians, neonatologists, and anaesthetists, in the provision of care to women and neonates considered to be *at risk.* This ambivalence is evident in the following excerpt from an interview with a midwifery educator who appears to struggle with reconciling the holistic concept of a midwife's role with the need for specialised knowledge and skills within a *high tech* environment.

> *If you can't give the high tech stuff then I don't think the midwifery education is adequate ... now there are probably degrees of high tech and that's when perhaps we are going to have to call in high tech staff. ... Midwifery isn't just the care of the normal, it is also the high risk, but I think in the future we are going to have specialists - like we have ICU specialists, and so I would think that there will be some one who specialises in high risk and whose skills are beyond those of the average midwife who is working in the average labour ward or neonatal nursery.*

The range of midwifery care, from the care of the *normal* woman and neonate to the care of *the high risk*, was provided for to some extent within level 2 and 3 service organisations through the different models of service delivery. These models reflected

the need for specialisation if women were to be offered birthing choices, and have access to the appropriate level of care required for their safety and well being.

7.4.3 Models of service

Data revealed a strong link between models of care and levels of service. Identified models of service delivery were categorised as: *Specialist Obstetrician Hospital Care; General Practitioner Hospital Care; Birth Centres; Alternative Birthing Suites; and Domiciliary (home or community).* These models of service could be provided by all levels of organisations to a varying extent.

The models of service provided by each practice setting impacted upon midwives' opportunities to practise throughout all stages of childbirth. When this model of care with its philosophical base was clearly defined, midwives were able to make a choice prior to their employment in terms of their compatibility. In situations where models of care were less defined and organisational policies and procedures reflected technical procedures rather than a service delivery philosophy, midwives often found themselves providing obstetric care within a circumscribed medical model. Each model is discussed in the following section from the perspective of its limiting or optimising influence on the opportunities for midwives to practise throughout all stages of childbirth.

7.4.3.1 The Specialist Obstetrician Model

The dimensions of the specialist obstetrician model of service delivery were found to be diverse. Geographic factors, organisational structures, and public and private maternity services, impacted on this model which in turn influenced the practice of midwifery. In hospital settings, specialist obstetricians were involved as primary care providers throughout antenatal, intrapartum and postpartum areas. This was according to policies and procedures determined by the organisation and approved by the specialist obstetricians. As such they usurped the role and responsibility of a midwife. The range of care provided by specialist obstetricians spanned from *normal pregnancy and childbirth* to care of *high risk* women and neonates.

The *Specialist Obstetrician Model* of service delivery was the established service delivery model within all level 3 organisations and the majority of the level 2

organisations. This did not exclude the provision of other models of care within these organisations but it did affect the extent to which other models of service delivery were encouraged and developed.

Midwives' opportunities to practise throughout all stages of childbirth within the Specialist Obstetrician Model of service delivery reflected the wide span of specialist obstetrician care. Numerous factors affected the midwives' ability to optimise practice opportunities within this model, but the factor remaining constant was the midwives' dependence on the specialist obstetrician in determining the midwives' sphere of practice. Where specialist obstetricians were employed as medical staff within a hospital they often encouraged midwives to provide care throughout the antenatal, intrapartum and postpartum stages for normal pregnancy and birth. In contrast, visiting specialist obstetricians were seen by midwives to guard their own perceived practice domain, which limited the role of the midwife to that of an obstetric nurse. The primary function of the obstetric nurse was to assist the obstetrician as directed. The midwives' practice was controlled through policies and procedures approved by the obstetricians. In addition there were *standing orders* stating the procedural and treatment preferences of each obstetrician that midwives were required to follow.

Midwives spoke of their interdependent relationships with the obstetricians. It was evident that midwives were given greater opportunities to provide care to the public patients under the care of a specialist obstetrician. This is illustrated in the following excerpt that typifies the situation:

> *The vast majority of women who use our facilities are uninsured. There are only a small percentage of privately insured women, but the good part from our perspective is that all the women who come through this unit who are uninsured are delivered by the midwives. We have an obstetric registrar here doing her diploma but once they've been here for a few weeks they're more geared towards the complicated things so they work with the obstetricians in that regard. If someone came in here now who was a hospital patient and was being cared for by the obstetricians the midwives would admit them. We would notify the obstetrician that they were here in labour, and from there we continue on with their care, we deliver them, and look after them postpartum. For the 20 or 30 per*

cent who do come through here privately insured it's the age old problem of looking after them right through labour - not having access to them antenatally is a problem with private and hospital patients - with the private ladies, looking after them through labour and then having to step aside because the obstetrician comes in for the delivery, steps aside again and leaves the midwife to provide the postnatal care.

In contrast the limiting effect of the Specialist Obstetrician Model of Care within a private hospital is demonstrated in the following excerpt:

Being a private hospital some of the doctors get upset if they miss their deliveries so its not hands on, its watching. Most of the doctors definitely want to be there. They've looked after them for nine months ... . The vast majority of the doctors are obstetricians, there are only three GPs . Postnatally the obstetricians come every day bar Sunday - they usually have Sunday off. They come to the desk and ask how Mrs ----- is, and if we say everything is fine they'll go in and talk to the patient, everything OK?, and they don't usually even touch the patient. Some will feel the fundus and check the peri (sic), but a lot just walk in, and if we are happy they won't check anything, just have a chat. Nine times out of ten the doctors make the decision about when they go home ... I think really midwives are competent to attend to these women postnatally, and to decide when the women are ready to go home. Really for your normal healthy postnatal patient I don't believe there's any need for the doctor to come, maybe once or twice, to talk about contraception ... which is an untested skill for midwives in this hospital.

The interdependent relationships of the obstetricians and midwives enabling the obstetricians to sustain their busy practices, and midwives to optimise their practice opportunities within the private setting, is described in the following extract:

I think that when you're dealing with obstetricians - and here in this hospital we have superb obstetricians - and here in the city you have a concentration of the quality. You may have some that may be a little behind, or a little tired, or fed up, but overall even ones in that category have very good quality knowledge. So I think midwives when they work

under good quality obstetricians tend to be observers and recorders. They don't actively participate, many of them, they don't actually see themselves as being part of that labour, but there are things that they can do that don't have anything to do with that obstetrician. And I think that obstetricians expect us to know what our work is and to fulfil it, and to provide it, so we don't need to be continually referring to them for guidance expecting them to tell us how to manage a normal labour. And in fact in this hospital we have a superb relationship with them all and they expect - rely upon us largely so they can get on with their business out there. We all know that they couldn't run their lives as they do if they had to be closer involved in labour.

A Director of Nursing of a large public teaching hospital spoke of the historic aspects of the Specialist Obstetrician Model of service delivery. She spoke of maternity care being comprised of:

obstetrics with a medical connotation and midwifery with a midwife connotation. We have tended in Australia to fall in with that model with both types of care being delivered. ... Australia is one of the few countries in the western world where it is normal to have specialist obstetrician care when having your baby. In most countries it is more normal to have a general practitioner or a midwife. So although midwives have had the early legislation in this state to practise independently, we have, because of the health system, become subsumed in our practice by working with doctors and in many cases, certainly in institutions like this, with specialist medical obstetricians for care. From the very early days this hospital was set up by women for women and it functioned as such with the input of obstetricians, but the midwives then did most of the care. I think when the university department set up in this hospital in the late fifties early sixties that was when that particular model would have come in.

Within public teaching hospitals an integral part of the Specialist Obstetrician Model of service delivery was the inclusion of medical students, residents and registrars as medical staff working under the direction of specialist obstetricians. This often had a

limiting effect on the midwives' opportunities to practise throughout all stages of childbirth, as there was the additional competition for practice opportunities. In particular, the opportunity for midwives to conduct normal deliveries was curtailed because residents needed a specific number of deliveries to meet their own clinical practice requirements.

7.4.3.2 The General Practitioner Hospital Model

Provision of care in the General Practitioner Hospital Model was closely integrated with levels of service delivery. It was the dominant model within level 1 service provider organisations. The effect of this model of service delivery on the midwives' opportunities to practise differed from setting to setting, and more particularly between general practitioners themselves. Interview data presented this model of service delivery as being strongly influenced by the interactions between midwives and medical practitioners. Interactions were based on a complex conglomeration of contributing factors that were not clearly defined by the midwives, but appeared as a recurring phenomenon throughout the interviews.

The underlying factors that presented consistently throughout the data were related to judgments made by midwives as to the competencies, availability, and reactions of general practitioners to actions taken by midwives in certain situations. Excerpts from interview data demonstrate these factors. Such interactions, as presented here, affected the opportunities for midwives to practise within antenatal, intrapartum and postnatal *General Practitioner* maternity care services.

An English midwife working in a *General Practitioner Hospital* spoke of the frustrations she experienced in the antenatal care provided within this model of service. Her comments reflect those of other midwives in similar situations.

> *If you were in my situation you would understand the frustrations I feel, because I feel that my skills are being removed from me. That's why I needed to do some independent work- to maintain my skills - to learn how to palpate again, to learn how to pick up a problem antenatally. There is no antenatal care by midwives what so ever. There's no history with the patients when they come in - you have no history. You don't know when their bloods were taken for Rhesus antibodies. You don't*

know the last time their haemoglobin was checked. People wander into labour ward having had their Hb done at 14 weeks and never again! And then they have a PPH (post partum haemorrhage) *and then you find out that the Hb is 7.6 - and it's just disgusting that the care is like that. These people are paying for their care and they should get optimal care, not lackadaisical care ...* (more clinical concerns expressed). *I believe midwives should be getting to know patients and their families during the antenatal period but instead women are going to the GPs rooms for their antenatal care.*

During the intrapartum period concerns were expressed regarding the effects of the General Practitioner Model of service delivery on the opportunities for midwives to practise. These were linked to the availability of medical practitioners for delivery and their attitudes towards midwives conducting the delivery in their absence. Midwives spoke of having to know what each general practitioner desired and having a willingness to abide by their wishes. Where repercussions from the doctors were not expected to be of concern, midwives often took the opportunity to call the doctor only when delivery was imminent. Providing the progress of labour continued satisfactorily, the midwife would conduct a normal delivery, knowing the general practitioner would be arriving soon after and be present should any complications occur. This practice was more common for public patients than for those who were privately insured, and was expressed as follows:

We get to know the doctors pretty well. Most of them expect us to make sure they get here on time for their private patients. The women expect it too. They can be very disappointed if their doctor doesn't make it - even if they are happy with the midwife. We can pick and choose more with public patients, but most GPs still like to be called in time - if it suits their timetable. Even if they arrive late they do like to attend. Some like to take over as soon as they walk in but most are happy to let the midwife continue.

General practitioners left the postnatal care of the normal mother and baby to the midwife. Some midwives spoke of the *trust* the doctors had in their ability. This was demonstrated in the seeking of advice from the midwives as to when women were ready

for discharge. Midwives also completed the necessary discharge documentation, however, the responsibility of discharging the women and their babies remained with the doctor.

With minimal involvement by general practitioners in postnatal care, midwives were seen to be the primary care providers during this period. Women were referred to early discharge programs conducted by midwives and to the community health nurse for each area.

7.4.3.3 The Birth Centre Model

The Birth Centre Model of service delivery was very popular with midwives. It was considered to be a model that encouraged women to focus on the normalcy of childbirth and provided a family centred holistic approach throughout all stages of pregnancy and childbirth. It was also a model that could be made available at any of the three levels of service delivery.

Birth Centres had a clearly defined philosophy that was readily available to midwives working within these settings. Guidelines were set through the organisations' policies and procedures stating the criteria for women to be eligible to receive this model of care. This ensured that only uncomplicated births were conducted at the birth centres. The Birth Centre Model was perceived by midwives as allowing them the opportunity to practise throughout all stages of childbirth, and to act as autonomous decision makers within established practice parameters.

Birth Centres visited by the researcher showed flexibility in their policies and procedures. The philosophy behind this model of service delivery was based on the role of the midwife to provide holistic care to women who were deemed to be at low risk, and who had an expectation of a normal birth. Criteria as to what constituted unacceptable complications for birth centre care were determined by visiting consultant or staff obstetricians, in conjunction with midwives working at the centres and the nursing/midwifery administrators. Common to all birth centres visited was the high level of satisfaction expressed by the midwives and the women who attended the centres.

The following excerpt is from an interview with a midwife administrator who had been involved in the planning and setting up of a busy birth centre in Sydney, and who had continued to be involved for the three succeeding years. She recounts:

> *We employed the whole team of midwives right at the setting up of the birth centre, and interestingly enough they are the same midwives that are still here three years later! I think this says that they are happy (laughter) and everyone knows everyone else, and we are now getting women having their second babies. They come back saying "oh, is so and so still here?" and yes they are, so it's working out well for everyone. And, of course, the other thing is, where is there to go to? because apart from going into independent practice, this is the next best thing. The way I see it is that I don't think any of the staff here could go back and work in a labour ward, having had the autonomy that we have here.*

Continuity of care was central to the philosophy of the Birth Centre Model of service delivery. This is what the same midwifery administrator went on to say :

> *While the birth centre philosophy of holistic care has spread through to birthing rooms attached to the labour wards they still don't have the midwifery antenatal care that's continuous through to the labour, and the same midwives, because we have a midwives' clinic here which functions the same as the birth centre, but come the labour and that's it - you have a whole new set of midwives who look after you in labour. And sure, that's fine, but I don't think that's optimal. ... There are eight of us all together here and we try to make sure that the women meet every body during their antenatal visits, but even if they did miss meeting a particular midwife and she turned out to be the one looking after her in labour, they would know that the philosophy towards the birth would be the same.*

The Birth Centre Model of service delivery affected midwives' opportunities to practise throughout all stages of pregnancy and childbirth in both optimising and limiting ways. With normal pregnancies the midwives' opportunities to provide antenatal care and education to the childbearing women and their families were enhanced. The midwives

assumed responsibility and conducted deliveries on their own. They also provided postnatal care for the women and their newborn babies. Limitations on their opportunities to practise occurred through the lack of on going postnatal care resulting from the early discharge of mothers and babies. Limitations also occurred when complications arose. Midwives were unable to continue caring for women, as they had to be transferred to hospital labour and delivery wards.

Birthing Centres differed in the levels of participation of obstetricians and general practitioners within this service model. The effect of the public and private health insurance status of the women was a determining factor. Public patients were considered to be the responsibility of the midwives, who would refer to a medical practitioner for an initial medical assessment and for a provider number approval required for the ordering of pathology tests. Birth Centre policies and procedures also provided guidelines on the number of obstetrician visits required during pregnancy. There was however, scope for autonomous midwifery practice. The intricacies of the interactions in the Birth Centre Model are highlighted in the following extract:

> *There are four different ways women can come through the birth centre. The first is Medicare cover, and that's about 60% of all bookings. We call them 'our' patients. They receive full care from the midwives. Once a week we have one of our VMO (visiting medical officer) do a clinic here and every woman booked here is seen by him and he supposedly does a medical to see if they're suitable and there's no major problem. But you could say that we have already screened them because we do their booking visit - information, history taking, all that sort of stuff, and then the second visit with him. We do all our own ordering of tests but one of our main dilemmas is that we cannot sign request forms, so whether it's legal or not, this is the way we do it. We get a whole heap of forms, page a resident, invite them down for a coffee, say "here, sit down and sign these forms for us", or we get the visiting medical officer to sign them when he comes in. ... we have tried and we will keep on trying to get routine tests ordered and signed for by midwives ... we compromise and do the best we can but it is a bit annoying ... it does*

seem ridiculous considering the residents know nothing at all about the women, or the reasons the tests need to be done!

Finding ways for the smooth functioning of the Birth Centre appeared to be a constant endeavour of the midwives. There were, however, times when midwives, obstetricians and general practitioners, shared a common philosophy towards birthing. This is reflected in the following quote:

40% of women coming through (the Birth Centre) *go and see their own private obstetrician and she will say that she wants to go to the Birth Centre and he will say "that's fine" (not all agree but a few do!) and so they come and see us and we run information evenings for both private and public patients, and we book them in. Then we have a shared care arrangement. Their main care giver is their obstetrician who they pay for. He does all their tests and everything, and they see us about three or four times in the pregnancy. They come in in labour, we look after them in labour, keep in touch with the obstetrician the same way they do in other places, and the obstetrician comes in for the delivery. He will either do it, we'll do it, or some of them have arrangements where they will just be a back up ("I don't want to come in unless there's a problem"), we just negotiate and see what they want to do. That's the second most popular way people come through the birth centre. So that's good, and we have good relationships with the obstetricians, about five, who come through here, and we have good support. We also have a staff obstetrician who sends his private patients here, and he's very supportive and will be a back up for women who only want a midwife but need to be seen by an obstetrician just once in their pregnancy.*

Then the other way we have just started to have women come through the birth centre is through shared care with GPs accredited to this hospital. They alternate with the GP and the midwives for their antenatal visits up to 37 weeks and then they see just the midwives here. That GP isn't involved in the delivery but they are followed up postnatally by the GP through the early discharge programme.

The notion of shared practice between medical staff and midwives that occurred in Birth Centres was also extended to independent midwives. Their involvement in the Birth Centre Model of care is explained below:

> *We have five independently accredited midwives and they basically use the centre for its facilities. They do all their own antenatal care in their rooms or the woman's home, and they bring the women in in labour, look after them here in labour, and then after the birth if everything is fine, they take them home. Those midwives are also accredited to the labour ward so if the woman has to be transferred the home birth midwife can go with them.*

In the Birth Centre Model of service delivery continuity of care was interrupted during the postnatal period. Women were encouraged to participate in early discharge programmes conducted by midwives outside of the birth centres. Discharge usually took place 6 to 12 hours after the delivery. Women could still contact the birth centre midwives for advice over the telephone, but it was the early discharge midwives' role to provide postnatal care to the women in their homes. Such practice was acknowledged as a compromise to the concept of continuity of care that was integral to this model of service delivery. This is portrayed in the following quote:

> *The only thing we don't have that I originally would have liked to have had is full midwifery care in terms of doing follow up postnatal, early discharge and 6 week postnatal visits which would have been a real total - but as it has turned out we would have needed more staff and we would have deprived a lot more women of having their babies here, so now we link in with another group of midwives who do that. So we have to sort of compromise but we work in well with the early discharge programme - they're a fabulous team. A lot of people have suggested that the birth centre and the early discharge programme are the best things about the hospital, and it is certainly becoming more and more popular. We are having up to 54 births a month and on the increase.*

Economic factors also influenced the utilisation of midwives within the birth centre model of service provision. Birth Centre midwives were very conscious of the importance of the cost variation in models of service delivery. Midwives working in

these settings were involved in evaluative studies comparing the costs of the Birth Centre Model and its outcomes for women and their families. Other centres had been evaluated through external financial planners as was the case in this instance:

> *This whole hospital has had a lot of rationalisation happening because they blew the budget last year. So they're cutting things left, right and centre ... these well known management consultants ---- came to me and they said "now labour ward has this many full time equivalents staff and they have this many deliveries. Birth Centre has this many deliveries and they have this many full time staff. Why is this so?" So I said "sit down and let me tell you why this is so". They had no concept of antenatal care, no concept of postnatal care with early discharge following up to 12 hours here, and when I was able to give them our hours of service and how much time we spend with the women, the amount of women who come through here, they put it all together, put it into their computers and came out with this figure that showed that the birth centre runs at the highest bench mark of productivity and cost effectiveness, in comparison to other labour wards and outpatient departments. That only happened last week, and we were called up to the general manager of the health service and patted on the back!*

The core process of *Optimising Holistic Midwifery Practice Opportunities* was evident in the Birth Centre Model of service delivery. Optimising behaviours demonstrated by the midwives included: *empowering of women; confident clinical competence; developing interpersonal relationships with the women, other midwives, and medical practitioners; collegiate relationships among maternity service providers; advocating for the women and their families; negotiating for increased practice opportunities;* and throughout these interactions remaining *with women.* Specialist obstetricians and the general practitioners who shared the Birth Centre Model's philosophy of normalcy of birth, choices for women, and continuity of care often practised collaboratively with midwives within the Birth Centre Model of Care.

7.4.3.4 The Alternative Birthing Suite Model

The Alternative Birthing Suite Model of service delivery was available in all levels of organisations. There was a wide range in the actual care received by the women and their families. In some instances there was little difference between this model and the Birth Centre Model. In other situations midwives stated that the philosophy of the family centred holistic approach was *only skin deep.* It was nothing more than having ascetically pleasing, homelike decors; a minimal level of medical intervention; and a place where women were offered a choice in labour and birthing positions. These factors were not always available in the traditional labour and delivery wards.

Midwives providing this model of care also worked in the labour and delivery wards providing the Specialist Obstetrician and General Practitioner Hospital Models of care. A variety of attitudes were prevalent towards the concepts behind the setting up of alternative birthing rooms. In some organisations the rooms had been set up in response to the birthing reviews and consumer studies. Where there was no strong support for this model of service delivery from the midwives the rooms were often poorly utilised. Where midwives had welcomed the emphasis on normalcy and family support within a more homelike environment, the concepts of the alternative birthing suites had spread to all the labour and delivery wards. This had resulted in better outcomes for a greater number of the women and their families. The following excerpts illustrate the effect of this model on the opportunities for midwives to practise throughout all stages of childbirth:

> *We call it a birthing room because it's been done up with nice curtains and furniture and a three-quarter size bed so women can be there with their families. It's there for women who just want to do things as natural as possible. They can walk about and shower when they like, and it's apart from the other labour wards. Mind you now that the women are being encouraged to take an active part in their labour and birthing all the labour and delivery rooms have taken on the birthing room concepts. Through the quality assurance reports showing that women want a bath in the labour ward we have won the war and they now have two baths. So now the birthing room is used more often for women wanting privacy and quietness while all the labour wards are used as birthing rooms and*

women are allowed to do what they want. If they want to squat they squat, if they want to stand they stand, and if they want to lie down they lie down. At least this is so for the public patients. The private patients don't really get that choice because none of the obstetricians are into encouraging active birth.

The Alternative Birthing Suite Model of service delivery provided women with birthing choices, and the opportunity of being active participants in the birthing process. This allowed midwives to encourage normalcy in childbirth. The model, however, did not in itself enhance the midwives' opportunities to provide care throughout all stages of pregnancy and childbirth. Opportunities to practise antenatal, intrapartum and postpartum care were influenced more by the levels of service provided, the policies and procedures of the organisation, staffing methodologies, the public and private health insurance status of the women, and the interactions between medical practitioners and midwives.

7.4.3.5 The Domiciliary Care Model

The Domiciliary Model of care was considered by midwives to more closely reflect the sphere of practice described by the WHO *Definition of a Midwife.* It was a model that provided midwives the opportunity to practise in all phases of antenatal, intrapartum and postnatal care, and to be autonomous decision makers. Midwives in private practice were interviewed by the researcher in New South Wales, Victoria and Western Australia. They spoke confidently of how they provided family focused care that was determined by the women and their families. The approach was flexible but the philosophy of care was constant. The desires of the women were paramount and respected in whatever setting the service was provided.

The care provided through this model was holistic and catered for all members of the family who wished to be involved. Friends who were considered by the women to be support people were also involved in the care either actively or passively as they chose. The following extract from an interview with a Victorian midwife, in private practice, and who also worked as a community health educator, demonstrates these concepts:

My independent practice is separate to my work here. It's really midwifery in the true sense of the word. We are there to empower the women so that they come out of this experience feeling fantastic about themselves and the job they have done, regardless of what that is, so that they bond well with their babies, and feel good about themselves. It's being able to care for a woman during the antenatal period, being able to provide antenatal education, not on a formal basis but on a one to one ... and attending them in labour, from the time they get their first contraction they know they can ring me. So that's continuity. It's something special for me . Now, attending them in labour can be in a hospital or a free standing birth centre or at home - wherever the client chooses to be. I've got practising rights at two small maternity hospitals here in Melbourne, private hospitals, which is great because it means we can go to hospital and I can continue as the primary care giver. They can either stay for a couple of days in hospital, as some women choose to, or they can go home right away and I'll continue their care at home. Now that I've done Maternal and Child Health I find that the continuity can last for up to two years. That's really nice because I've got people coming back for third and fourth babies.

The optimising behaviours demonstrated by midwives in private practice were more fully developed and evident than amongst midwives providing care within other models. The *Core Consequence* of the optimisation of opportunities to practise throughout all stages of pregnancy was that midwives *were Able to Practise to the Full Extent of the WHO Definition of a Midwife.*

Numerous factors, however, limited the midwives' opportunity to practise within this model of service delivery, and other models providing opportunity for continuity of care. Schema 2 (p. 200) depicts the action/interaction conditions that adversely affected opportunities for the midwives to practise to the full extent of the WHO Definition of a Midwife. Contextual categories contributing to limitation of opportunities are nominated as interactions within and between practice settings, consumers, the nursing and midwifery professions and the medical profession. Sub categories within practice settings have been described in this section of the findings as

geographic factors; organisational structures; levels of service; public and private health care; and models of service delivery. The following section will discuss the impact of consumers on the opportunity for the midwife to practise to the full potential of the role.

7.5 Consumers

The effect of consumers on the midwives' *Opportunities to Practise Throughout all Stages of Childbirth* was made evident through the interviews with the midwives in the diverse practice settings. Schema 2 (p. 200) depicts sub categories impacting on midwives' practice opportunities as: *lack of recognition of the role of the midwife; lack of information regarding choices of models of care; and medical dependency.* Contributing to, and interwoven with, these sub categories were social factors, women's health policy issues, and historic and cultural factors. The conceptual category encompassing these diverse influences was nominated *consumer awareness.*

Schema 3 (p. 266) depicts the cyclical consequences of optimising actions/interactions by midwives within the context of developing consumer awareness of the role of the midwife. Where optimisation of consumer awareness was evident women were: informed about birthing choices; conversant with the role of the midwife in providing maternity care within various models of service delivery; and empowered to exercise choice and control.

7.5.1 Lack of recognition of the role of the midwife

The effect of the community's lack of recognition of the role of the midwife was emphasised by this Director of Nursing of a large teaching hospital for women. She states:

> *Until we do something with that community image no one is going to go to the midwife who can go to the best professor in* ---- (name of city) *who is an obstetrician, so there is a big community change required in terms of their thought of midwives before midwives will achieve their place that they want in midwifery. ... To allow midwives to do the things they are saying they want to do, and that is to have their own patient and client group, there needs to be sustainable change in terms of legislation. But they are up against mass forces ... . Even in the community*

consultation we did at this hospital some years ago, midwives were almost last on the scale, of women asked who do they want to deliver their baby. So we don't have an image of being able to do it, and until something is changed at legislative level then we are never going to have an image of being able to do it.

According to this Director of Nursing sustainable change could not be achieved without legislative changes that allowed midwives more accountability for their own practice. In addition, midwives themselves needed to assume more responsibility in decision making.

I also think midwives have to stop subsuming behaviours ... using phrases like "I have to ask the doctor" or "that's the doctors orders" or "that's the doctors, that's the doctors, that's the doctors". So while you keep up with that you are not seen as having the ability, the authority or the skill. But if the midwife took up her own responsibility and accountabilities, and could be sued the same as the medical staff, well I think these things might change!

This Director of Nursing also expressed her perceptions of midwives' interactions with the women in their care. She referred to value judgements made by midwives that detracted from empowering women to manage their own, and their families' care.

It's all these value judgements that are made about people - "Oh, she is never going to cope. She is hopeless ..." So I don't know how you get these value judgements out of the way to enable the midwives' skills, talents and knowledge to be seen by the community as valuable. It can't be valuable if you keep getting complaints about the myriad of information that people are giving in regard to breast feeding. It can't come about unless each of us have respect for one another as colleagues and respect each others knowledge and skills instead of pushing that down in front of the patient, and in particular you see it with breast feeding ... .

There was also the need expressed for improved clinical care by midwives if consumers' satisfaction, and appreciation of the role of the midwife, was to be enhanced. This is

demonstrated in the following extract from a midwife responsible for quality assurance within a large teaching hospital:

> *I've always known that we can do things better for the women than we have traditionally done them. We must be able to provide them with a service that is much more user friendly. So how to do that is the most perplexing question ... so I've been sent over* (to the UK) *to have a look at team midwifery programmes there and to implement team midwifery here in this hospital.*

Continuity of care was considered a key determinant for recognition of the midwives' role by the community. Where midwives were constantly interchanged throughout each woman's pregnancy and childbirth they remained anonymous and subsumed as *hospital staff.* Women had the added pressure of adapting to a continued change of midwife at a time when they were seeking ongoing support, understanding and empowerment to give birth and bond with their newborn. Compounding the effect of lack of continuity of care by the midwife was the firmly entrenched social concept of the doctor as the primary care provider of maternity care. This concept was demonstrated by the women as a state of medical dependency.

7.5.2 Medical dependency

Consumers' expectations and their understanding of the role of the midwife as a secondary care giver to their doctor were clearly demonstrated through the comments made by midwives in various settings. It was particularly emphasised in private care settings. For example:

> *The majority of the doctors make it for the deliveries. ... A lot of the patients will say, even if the midwife has delivered them and they've got no stitches, and they're perfectly fit, hale and hearty, " I wish my doctor was there for the delivery". Like they feel they're paying him all this money for the delivery and they want him there for the delivery.*

This expectation that the doctor should conduct the delivery differed among midwives. In particular, those who had practised in the UK considered it a lack of recognition of the midwife's role. An English midwife expressed her frustration with the lack of

recognition of the midwife's role, by Australian childbearing women and their families, as compared with her experiences in the UK.

> *The midwives are more highly thought of over in Britain. There was none of this, "he's my doctor and he's going to deliver my baby", so we tended to get a lot more experience. You are thought of more as a practitioner, and I thought it was going to be the same over here but ... that's why I'm a bit frustrated. Your confidence and your level of skills obviously improve a great deal when you've got all of those factors acting in your favour. You've got all the women coming in expecting to have a midwife deliver them and expecting everything to go normally, and having more confidence in the midwives themselves, and knowing that if anything should happen the midwife will get in touch with the doctor then, and not have the doctor come in and examine the woman and then go off, and the midwife be with them all the way through everything, and then in the end the midwife phone the doctor for him to deliver the baby. It's just a completely different situation here.*

Another English midwife spoke of having to make adjustments to the lack of community recognition of the midwife's role. Again comparisons were made with the perceived acknowledgment of midwives as practitioners in their own right in the UK.

> *I find people over here very accepting. I find ladies here tend to look to the doctor as the person in control of their maternity care. I've even had ladies say, "I'm having problems breast feeding. I'll ask doctor so and so when he comes in", and you think, well maybe I could help?* (Laughter) *You know, that sort of thing.*

The dependence on the medical practitioners reflected the dominance of the medical model of care compared to all other models. This is discussed more fully within other defined categories affecting the practice opportunities of midwives. Its link with consumers' awareness of the role of the midwife in providing maternity care services was evident throughout both the survey and interview data. The following quote expresses this notion opinion quite plainly:

> *Doctors are the biggest obstacle- with a capital D! No doctors should be around for normal pregnancies and childbirth. We are calling doctors*

in for normal deliveries, and nine times out of ten they miss it, and they don't mind, it doesn't worry them, we just call them because we have to, but I don't think that we should have to. Abnormal - my god, take her please! But with a normal pregnancy, normal birth, and normal postnatal period, you shouldn't have to see a doctor. And we should have power to script our own drugs like they do in the UK. We are lucky in K----- because we can do more, but that's basically because the GPs are so busy, and there are so few of them with so much to do, and they just trust the midwives.

The differences between the expectations of the women receiving private care and those in public settings again affected the opportunities of the midwife to practise throughout all stages of pregnancy and childbirth. The effect of private and public maternity services and their impact on the midwives' opportunities to practise throughout all stages of childbirth has been demonstrated in the preceding section of this chapter.

7.5.3 Lack of information regarding choices

The predominance of comments reflecting the UK experience of community focused care is demonstrated in the following excerpts. UK midwives practising in Australian settings, ranging from level 3 teaching hospitals to domiciliary home births, all referred to the difference in the recognition of the role of the midwife amongst the communities of the two countries. A UK midwife gave her opinion of the underlying factors affecting the lack of recognition of the Australian midwife's role by the community as follows:

In the UK everyone knows who the midwife is. Children grow up with the midwife visiting their homes for antenatal visits and to look after the mother in early labour. Often the mother is only in the hospital for the delivery and then the midwife is back in the home looking after her for the postnatal period. She becomes part of the family. Here (in Australia) *people often don't know who the midwife is, or what she does, unless you link it in with the medical profession and the hospital setting - they just don't have a clue. Whereas in the UK everyone knows who the midwife is. They see her in the domiciliary setting - they seem to have*

really got things together. ... Australian midwives are up against it- I mean, I don't think a midwife will ever be a midwife in Australia. There's just too much hard work to do!

Australian midwives were often as accepting of the status quo in regard to limited choices of models of maternity care as were the consumers of these services. A coordinator of midwifery services in a large private hospital described how she perceived women were offered informed choices regarding their pregnancy and childbirth. Within the private setting it commenced with the initial visit to the woman's own GP who would then refer her to an obstetrician for the rest of her antenatal care. Choices discussed with the woman centred around the Specialist Obstetrician Model of care. The obstetrician remained the primary service provider throughout pregnancy and was expected to conduct the delivery and monitor postnatal care. In the private setting this was the expectation of women whether or not they were identified as high risk. There was no indication that the women were dissatisfied with this model of care, and according to midwives interviewed in these settings, women returned to the same obstetricians and hospitals for subsequent deliveries.

During interviews with midwives in these private organisations chosen by women with health care insurance, reference was made to the obstetrical outcomes for the women receiving this model of care. There was a marked increase in medical intervention for women choosing this model. In a large private hospital visited by the researcher, statistics showed Caesarean section birth rates were over 30%, epidural rates ranged from 50% to 65%, and normal spontaneous vaginal deliveries were as low as 45%. There was no indication that women were informed of these high intervention rates within this model of care, or that they had been offered any comparisons with models of care resulting in a much higher percentage of normal deliveries. This could be compared with a similar sized public hospital providing services to a lower socio-economic community, where Caesarean rate for a similar number of deliveries was 9.8%; epidural rate 3.7%, and normal midwife conducted deliveries 83.7%. (Rates given at the interviews with midwives in these settings were confirmed with Midwives' Data Collection statistics compiled by the health departments for each of the states, New South Wales Health, 1993; Perinatal Data Collection Unit, Health Department of Victoria; Health Department of Western Australia, 1994).

The different obstetrical outcomes are discussed in more detail in the section on the effect of medical intervention on the midwives' opportunities to practise throughout all stages of childbirth. In this section they are referred to in the context of consumers' choice, and are raised as an issue regarding the consumers' lack of awareness of alternative models of care, and subsequently their lack of informed choice.

There were implications of the consumers' lack of awareness of choice of models of care on the opportunities for midwives to practise throughout all stages of childbirth. The result was a dominance of the medical model of care that was continuously promulgated through consumers' choice.

Women attending public services were also referred through the medical system to public hospital obstetricians or general practitioners with obstetric qualifications who were accredited to practise within public hospitals. Again there was no indication from the interviews and fieldwork that alternative models of care were discussed with the women . Those consumers who actively sought alternative models of care were usually motivated by their own reading or social backgrounds where they had been exposed in some way to the concepts of other possible models of maternity service delivery. As many of the uninsured public maternity services' consumers were often from lower socio-economic areas, or non English speaking nationalities, there was little exposure to information regarding birth choices.

Optimising behaviours demonstrated by midwives that facilitated empowerment of childbearing women included; information sharing, education, respecting women's choices, and assisting women to overcome barriers to open communication. Midwives interactions with consumers were often influenced by their own awareness (or lack of awareness) of the role of the midwife within different models of care available to childbearing women and their families. Midwives' understanding of their own role was interwoven with the complexity of the interrelationship between the nursing and midwifery professions. Within this context the conceptual category of *nursing/midwifery integration* emerged.

7.6 Nursing midwifery integration

The sub categories depicted in Schema 2 (p.200) within this major category affecting midwives' opportunities to practise throughout all stages of childbirth were:

specialisation; multi skilling; education; lack of continuity; lack of recognition of the midwife's role; obstetric nurse/midwife; policies and procedures; and *legislation.* These dimensions of nursing/midwifery integration have been referred to within the categories of practice settings and model of service delivery as they affected those aspects of midwifery practice. Here they are identified within the major category of *nursing/midwifery integration.* The effect of actions and interactions between nursing and midwifery on the optimisation of opportunities to practise throughout all stages of childbirth is the focus of this section.

7.6.1 Specialisation

Within the context of nursing/midwifery integration, specialisation was referred to by midwife interviewees as aspects of maternity care that required additional knowledge and skills to what would be expected from all practising midwives, within a particular area of practice. These specialist areas included: neonatal special care; community health nursing; antenatal education; lactation consultancy, and advanced nursing/midwifery practice within specific settings. Specialisation in these areas was recognised by the completion of an accredited course of study within a particular specialty.

Midwives with these specialist qualifications, who had continued to work in their specialised area of practice, considered themselves to be neonatal special care nurses, community health nurses, antenatal educators, lactation consultants, operating theatre nurse/midwives, or gynaecology nurses, rather than midwives. The importance of their initial education as both nurses and midwives was acknowledged, but after years of specialisation they did not consider themselves to practise within the WHO (1976) Definition of a Midwife. This self assessment was based on their lack of opportunity to practise throughout all stages of childbirth. The consequence of specialisation was fragmented midwifery practice where particular aspects of midwifery were fully developed and utilised, and other aspects were under utilised.

While there was diversity of opinion on the origins of the core components of these specialties the trend was to recognise their derivation as being from either nursing or midwifery. This excerpt from a nursing administrator clarifies this anomaly:

> *Now take for example my own job currently as Coordinator of Clinical Nursing. I'm as responsible for the gynaecological care in the hospital as for the obstetrical care. Neonatology itself is a specialty. So we no longer have as an essential criteria to come into our neonatal intensive care course, midwifery as an essential, but we do require general nursing with some previous experience in either neonatal care or midwifery.*

This close link between nursing and midwifery had implications for both service provision and education. These factors are discussed in the following sections.

7.6.2 Multi skilling

The concept of multi skilling, and its impact on midwives' opportunities to practise throughout all stages of childbirth has been discussed within levels of service provision (p.222). The link between the categories of *levels of service* and *nursing/midwifery integration,* on multi skilling, is demonstrated in the interviews with midwives within the level one service providing organisations. It is also strongly linked with *geographic settings.* Examples of midwives' experiences with multi skilling have been discussed within these contexts.

The effect of nursing/midwifery integration on multi skilling was the limitation placed on midwives' opportunities to practise midwifery, through their dual professional qualifications. This was demonstrated through interviews with nursing/midwifery administrators who referred to the cliche *a nurse is a nurse, is a nurse, is a nurse.* The implication of this stereotyping was that midwives were essentially nurses with additional qualifications to practise midwifery. Midwives practising in settings where multi skilling between nursing and midwifery was considered essential to the efficiency of staffing organisations, were expected to accept being transferred to nursing areas of the hospital should it be required. In addition, there were country hospitals where midwifery clients were intermingled in the wards with medical and surgical clients.

The consequences for midwives who were coerced into multi skilling was that their opportunities to practise throughout all stages of childbirth were limited. Midwives stated that the needs of the childbearing women in these situations were secondary to organisational time restraints and they were unable to provide holistic midwifery care.

Midwives also expressed the personal pressure they experienced moving between illness and wellness models of care.

7.6.3 Education

There was a diversity of opinion on the effects of nursing/midwifery integration on midwifery education and its subsequent impact on opportunities for midwives to practise throughout all stages of care. Even at the individual level midwives were ambivalent about whether midwives required nursing qualifications prior to undertaking midwifery education, or whether direct entry into a midwifery programme would prepare midwives adequately for practice within the diverse settings throughout Australia. This ambivalence is demonstrated in the following comments from a midwifery educator who had been involved for 26 years in educating general trained nurses through a hospital based midwifery programme:

> *I think in Australia our midwives have been indoctrinated into thinking it* (midwifery) *is a specialised branch of nursing. Now admittedly I think that you do need all of the nursing skills but there is nothing to say that you could not learn all of those in a midwifery programme providing it is appropriate in content and development. Now, putting on the big picture hat, I can see that if you look at our state it would be less cost efficient to have midwife alone practitioners in the smaller units. Most of those midwives would be doing a number of other tasks as well. They would not be doing solely midwifery. This was always the argument put up by our Health Department and the Nurses Board, that for our geographical needs, you need the skills of a double, if not triple certificate to care. So it is a difficult one and I have always myself felt that a good core knowledge of general nursing principles is a good jumping off point. Now what length that initial core of knowledge needs to be - that's where I may be having second thoughts.*

A tertiary based midwifery educator also found that the future of midwifery education was a perplexing enigma. She stated:

> *I don't know what the answer is. As a true midwife I would like to see a direct entry for midwifery, probably at Bachelor level. I think that's the*

way to get them - when they're innocent, so to speak, and they have not been got at by the medical system and they're not already into the medical model. But my rational self looks at our isolation and the problems we face in Australia, and our problems are not the same as in Britain. So I think it would be very difficult to have direct entry midwives working in hospitals throughout Australia, given that the majority of midwives, rightly or wrongly, are employed in peripheral hospitals, and are expected to be able to work in general and in midwifery, and that's a fact. And midwives that I know loathe that fact and grumble mightily, but that is how it is so we either change the system from the top, and I can't see that happening for many years, or we try and change the system from the bottom up. But a twelve month post graduate midwifery course isn't enough to change the attitudes and beliefs that have been inculcated into our midwives for many years. It takes much longer than that ... .

While there was no consensus on the best approach for midwifery education there was agreement on the necessity for changes to present midwifery curricula. Practising midwives spoke of their misgivings as to the adequacy of midwifery education to prepare midwives to practise according to the WHO Definition of a Midwife. The following comments highlight this perceived deficiency:

We have tailored our needs to what the doctor wants. In our midwifery training in this hospital, the midwives have always worked under the direction of the doctors. The midwives are not out there practising on their own. The deliveries they do are done under supervision. Therefore they are not confident to practise on their own.

From another viewpoint there were concerns expressed on an integrated education program for midwives, as stated below:

I am concerned about the training of midwives. There is a swing towards "anyone can do anything", e.g. first year post graduates completing comprehensive courses. There is a focus on the theoretical and a paucity of practical experience. It could be very dangerous. Midwifery is a totally different world to general nursing.

The recurring themes throughout the interviews focused on the emphasis of the medical and nursing models on midwifery curricula, and the inadequacies of these models to provide a philosophical basis on which to prepare midwives to practise to the full extent of the sphere of practice defined in the WHO (1976) Definition of a Midwife. These concerns were expounded by this tertiary midwifery educator:

> *I think that the majority of Australian educated midwives don't possess the confidence to practise autonomously. They have not had that education and they don't believe in themselves ... . The few that do have that confidence find it exceptionally difficult to operate within a fairly hierarchical and authoritarian system. And I think a lot of it is because we are brought up, trained and educated, and I mean trained in its true sense, to think like nurses. That in itself is a real problem, because on the one hand you have midwives who are autonomous and free spirited like some of the British midwives who have worked in the community - and its the ones who have worked in the community that seem to have the most difficulty fitting into the hospital system. ... We give our students all this stuff about holistic care, the autonomy of the midwife, continuity of care, that the women's choices are paramount - we give them all that. We tell them about that in the lecture theatres and just the same as its been for generations of midwives, we send them out to the hospitals and they find that it isn't true at all!*

The integration between nursing and midwifery was extrapolated by the same educator to include the medical profession. This is demonstrated in the following excerpt:

> *There is so much contamination between the groups* (implied nursing, medical and midwifery). *They share a huge amount of philosophical and practical aspects, but in many other respects they are quite different. I don't see that as bad, but what is bad is the lack of respect, and the lack of equality, and the abuse of power that goes on between the systems.*
>
> *I suppose what I would like is that we start off with a midwifery model as the basis. Whereas now we start off with a nursing model , or not even a nursing model, we start off with a medical model, and from the medical model we try and change it slightly to incorporate a*

midwifery model. I'd like to turn it up side down, so we start with a midwifery model of care, and then we draw upon the medical model, and say, the neonatal model, or a model which has more holistic or naturopathic or homoeopathic aspects to it. We can bring in all that, but I think we are starting from the wrong framework. We are starting off with nursing theories, nursing concepts, nursing models, and using them, trying to adapt midwifery to fit these nursing concepts. ... And so far as I know nobody has tried to develop a midwifery model of care.

In addition to the ascendancy of medical and nursing models over a midwifery model as the conceptual framework for education, the hegemony of the nursing profession extended to legislation controlling the practice of midwives.

7.6.4 Legislation, policies and procedures

Within the notion of legislation, policies and procedures the effect of nursing/midwifery integration was most explicitly expressed. Midwives throughout Australia were regulated through the Nurses Acts of each State. Interviewees from Victoria referred to the Nurses Act 1958 (repealed in 1995) and the Midwives Regulations 1985 as limiting their opportunities to practise to the full extent of the *Definition of a Midwife* (WHO, 1976). Restrictions noted included Part VI 601, 602, and 603 which stated:

601. No midwife shall attend a woman or newborn child in the course of midwifery practice unless the woman or newborn child, as the case may be, is under the care of a medical practitioner for the particular pregnancy: ... .

602. A midwife shall not carry out prenatal supervision except with the authority and on the responsibility of a medical practitioner.

603. A midwife shall not make any vaginal examination unless instructed in a particular case by a medical practitioner to do so.

During the period of time when the interviews were being conducted in Victoria (1993) the *Nurses Act 1958* and the *Midwives Regulations 1985* were under review. Midwives expectations were that the revised Nurses Act would be more in line with the Western Australia (1992) and New South Wales (1991) Nurses Acts, neither of which included midwifery regulations. The position of the Nurses Boards in regulating the practice of

midwifery, however, was clearly stated. There was no requirement for midwifery representation on the New South Wales Nurses Board, while the Western Australian requirement was that one of the twelve appointed Board members be a midwife.

This apparent under representation of the midwifery profession on Nurses Boards with legislative power to *issue codes of practice for the practice of nursing or any nursing speciality and the conduct of nurses or nurses practising a particular speciality,* was not raised as an issue by midwives in New South Wales or Western Australia. References to the limiting effect on opportunities to practise throughout all stages of pregnancy and childbirth through current legislation were made by midwives practising in the state of Victoria. Their comments referred to *the outdated* legislation, and conveyed some apprehension regarding expected changes. This is portrayed in the following excerpt from a midwife in private practice in Victoria.

> *If the changes to the Nurses Act go ahead and we loose our Midwives Register, I don't really want to be called a nurse and flagged with a little tag to say that I've got midwifery qualifications. Terrible! I'll move to Western Australia if they do.*

The limiting effect of the Victorian legislation on the midwives' opportunities to practise to the full extent of the WHO (1976) is stated succinctly in the following quote:

> *The change* (to practise to the WHO definition of a midwife) *needs to be sustainable, and I don't know where it is sustainable in terms of legislation, to allow midwives to do the things they are saying they want to do. And that is to have their own patient and client group.*

This limiting legislation on midwives desiring opportunities for private practice can be compared with the following comments from a midwife in Western Australia:

> *Certainly in this State we had very early legislation to licensed practice and we have always had the machinery there to practise independently.*

The same midwife went on to say that the Western Australian legislation *makes it difficult, because of its legislation, to have a midwife alone qualification at this stage.*

This also applied to New South Wales and Victoria. Midwives in these three states recognised the need for legislative changes to take place before the concept of *direct entry midwifery* could be implemented.

The Victorian Nurses Act 1995 has brought Victoria in line with other states and territories. The Midwives Regulations 1985 were replaced by a Code of Practice for Midwives in Victoria on the 1st. of January 1996. This gave the midwife the legal right to provide care to the pregnant woman and her newborn *on her own responsibility.*

With the midwifery and nursing professions being controlled through common legislation and codes of practice, policies and procedures guiding practice reflected this integration. Midwives referred to nursing administration as having authority to determine policies and procedures, in collaboration with medical and hospital administration. There was little evidence of dissatisfaction with the effect of nursing/midwifery integration on policy and procedure determination. Limitations emanating from restrictive policies and procedures on opportunities to practise throughout all stages of childbirth were perceived by midwives to be generated from a complexity of sources beyond the control of nursing administrators.

7.6.5 Recognition of the midwives' role by the nursing profession

Midwives' opportunities to practise throughout all stages of childbirth were insidiously curtailed through interactions between the nursing and midwifery professionals. This included the level of recognition of the midwife's role by members of the nursing profession. A recurring distinction was made between obstetric nurses and midwives. Excerpts from the interviews are included here to illustrate the different properties of this nomenclature as used by midwife interviewees.

> *If we want to be midwives in the true sense of the word, we have got to work in every part of midwifery. Not to see the delivery suite as being the place to work, the only place for the midwife - the glamour icon and the whole box and dice of midwifery. A lot of people see it as that ... . When I found that out was when I tried to work team midwifery into the place. Now I've got it three quarters in but I had hell to try and convince people that people from postnatal were as capable of working in delivery suite as delivery suite were of working in postnatal. .... . While we have still got that and people don't see midwifery as antenatal, postnatal and intra natal* (pause) *separate, you know. Postnatal midwives? There is no such animal. But there are obstetric nurses! That's what I told them. I*

said if you want to be obstetric nurses you keep going the way you're going!

Midwives described by other midwives as obstetric nurses demonstrated characteristic behaviours such as a tendency to be influenced by the requirements of the obstetrician rather than focusing on the needs and desires of the women. The following quote by a midwife clarifies this concept:

> *They're* (obstetric nurses) *not uncaring towards the patient but they wouldn't think to initiate things, like suggesting to the women to have a shower, or walk around, change positions, try different things, you know - the power of suggestion goes a long way in helping the women through. They're probably very skilled when it comes to the woman having an induction, a delivery, an epidural, a post partum haemorrhage, you know, those sort of things, but I don't think they're skilled in using their natural initiative and trying to be supportive of seeing the woman through whatever sort of birth she is wanting to have .... I think they are very skilled at supporting the obstetricians.*

A delivery suite nurse manager who had worked for over twenty five years in this position spoke of her perceptions of the difference between midwives and obstetric nurses. The focus was on behaviours towards the women in their care. She recognised the core nursing knowledge and skills required by all *nurses working in delivery suite,* but emphasised the added dimension of caring a midwife focused on the woman could contribute. This is illustrated in the following excerpt:

> *The obstetric nurse will set the room up, have every thing organised, look after that woman, but won't share her knowledge and skills. I think they are nurses with midwifery added. I don't think a lot of them could go to the birth centre and provide that kind of care because it's that more open, warm fuzzy type of care that they promote there and there are a lot who can't cope with that sharing of themselves that is needed for that kind of care. They can give excellent clinical care but they have to come to terms with themselves before they can ... they have to feel safe and secure, and comfortable about themselves. There may be more security for some in high tech clinical skills. The extra warmth makes*

them (the midwives) *stand out, and its an extra for the women, but you can't knock the others* (obstetric nurses) *because they are providing the satisfactory, safe and competent skills.*

Midwives referred to their lack of opportunity during the antenatal period to empower women to take control over their birthing experiences through the sharing of their knowledge and skills with the women. The importance of antenatal access to the women was emphasised as a time when women seek knowledge and information to prepare themselves for the birthing experience. Midwives in private practice spoke of the importance of the time they spent in counselling and supporting women during the antenatal period. This time of preparation empowered women to draw upon their own knowledge and inner strength during childbirth. Midwives were able to recognise the strength of the women and to build a rapport with them. This empowered the women to retain control throughout the birthing experience. This was seen by midwives as a confidence building force that remained with the women as they faced the challenges of motherhood. In contrast, the empowerment of women was not a facet of the care provided by the obstetric nurses working within a fragmented model of maternity service provision.

The recognition of the full role of the midwife by nurses and midwives was an essential requirement for the optimisation of opportunities to practise throughout all stages of childbirth. The constant interchange of terminology that referred to midwives as nurses, obstetric nurses, or midwives was an indication that the integration between nursing and midwifery was deeply entrenched and its influence often unrecognised by nurses and midwives. This was in direct contrast to the midwives' perceptions of the subsuming effect of the medical profession over midwifery practice. Actions/interactions between medical practitioners and midwives are discussed within the conceptual category of *medical subsumption.*

7.7 Medical subsumption

The incorporation of midwifery with the all encompassing medical model of care was evident within all the major categories that emerged from the interview data. Practice settings, as diverse as specialist obstetrician hospitals to midwives in private practice, were governed by the medical structures, policies and procedures. Consumer awareness

of choices in childbirth were controlled by the medical profession. The nursing profession was dominated by the medical profession, and midwives were subsumed under this widespread medical umbrella.

The medical culture within each maternity service was influenced by interactions between the midwives and medical practitioners. Where midwives optimised their opportunities to practise holistic midwifery they became catalysts towards changing the organisational culture. The prevalence of optimising interactions was the determining factor enabling midwives to fulfil the WHO Definition of a Midwife (1976). Optimising interactions included the development of collegiate relationships based on a sharing of knowledge and practice, and a focus on the needs and desires of the childbearing women and their families. Midwives spoke enthusiastically of the benefits of a collaborative approach to midwifery care and its consequences for women and midwives.

The concepts, and consequences, of collaborative shared care are expressed by this midwife philosopher:

> *They* (midwives) *don't believe in their power. They still see themselves as the doctor's helpmate, the doctor's assistant. Whereas I believe they should be working in a collaborative sense, and I mean collaborative in its true sense. So that it is a real sharing, and that perhaps the doctor is the team leader sometimes, and perhaps the midwife is the team leader at others, and maybe they will swap, even in one case, so that they may actually be looking after the one person, but according to that person's needs at any one particular time, the team leader may be a doctor, or a midwife, or even be somebody else - may even be an obstetrician. They really do need to work on a team basis, and therefore the communication has to be so good they really can collaborate on an equal basis. ... I think that the hierarchical structures of the hospital based system and the medical model is such that this* (collaboration) *is prevented from happening.*

7.7.1 The medical model

The reference to the *medical model* as a dimension of the subsumption of midwifery by the medical profession was repetitive throughout the interviews with midwives. It

was seen as the philosophical underpinning of the hospital focused health services and the foundation on which health professionals developed their specialities. This is illustrated in the following excerpt:

> *The over riding model is a medical model, and while the medical model is perceived in the hospitals to be the only model, and that power relationships work to maintain that, then it does not matter if it is a nursing model or a midwifery model, we are always going to have a medical model with a bit of nursing and a bit of midwifery thrown in. ... We are coming from a framework that says every pregnancy is abnormal until proven otherwise, which sort of turns our midwifery philosophy up side down. I mean, within hospitals we practise from a medical model and try and be midwives within that.*

Midwives' perception of the medical model was that it was illness rather than wellness focused.

> *The focus is on the abnormal - what can go wrong? There is no confidence in the women, their strength and their bodies. Australian midwives follow this medical model. It's a whole different attitude because midwifery is integrated with surgical work, and this makes them nurses and not midwives, and that's in labour ward too. They can deliver babies but they still do it medically. It's a completely different approach* (to UK midwives). *They* (Australian midwives) *follow policies and procedure guidelines to the letter. I think if they used the procedures as guidelines, and not hard and fast rules, they'd be able to work a lot better as autonomous practitioners in their own right.*

The entrenchment of the medical model on midwives' knowledge and practice was expressed by this midwifery educator working in a private teaching hospital.

> *I think the problem is the education that we've come through. You know the physios (sic) have tended to do the childbirth education in this hospital because the midwives are very much in that hegemony of doctor's handmaiden. Our education was controlled by doctors. It's not that long ago that they were on our examination boards, and we still have them on our registration boards. I'm not so sure they have nurses*

or midwives on doctors' registration boards! And the physios here are saying they don't want midwives giving the education classes to the women because we are too tuned in to the sick, the abnormal. We're almost as bad as the obstetricians themselves at trying to medicalise (sic) the normal. It's a way of thinking that was forced on us. You know, you look at hegemony, what knowledge is of most worth, who has told us what is important. You know, in the labour ward the terminologies that we use are obstetric terminologies. They are not terms that women would use. We don't analyse what they are feeling. We don't ask them what it's meaning to them. We just say, "oh this is the presenting part, or this is the partogram" - you know, totally obstetrical terms. You just happen to be the woman we are doing it all on. And this is our education!

The effect of the medical model as a philosophical basis for the development of policies and procedures within maternity services, has been the limitation of midwives' opportunities to practise throughout all stages of childbirth. The consequence for midwives working within medically controlled hospital settings has been fragmentation of their holistic midwifery role, and the development of obstetric nursing specialities.

7.7.2 Medical dominance

The ascendancy of the medical model over alternative models of maternity care resulted in a medical domination of midwifery practice. Midwives spoke of adhering to policies and procedures as determined by medical practitioners, hospital, and nursing administrators. Where midwives in clinical practice acknowledged their contribution to the development of policies and procedures there was diversity in the levels of input. Midwives working in birth centres spoke of their involvement in developing policies and procedures at a practice level, but the over riding policy direction was pre determined at an administrative level.

Midwives' opportunities to practise throughout all stages of pregnancy and childbirth were controlled through organisational policies and procedures. During interviews midwives referred to these policies and procedures as determining all aspects of their practice. Decision making within hospital settings was based on these medically

approved policies and procedures. This ensured that in the absence of a medical practitioner, the midwife's practice was dictated through the medical profession, who retained the responsibility for the care of the childbearing women.

This retention of accountability by medical practitioners expropriated midwives' rights to practise *on their own responsibility.* This continuously reinforced the subordinate role of the midwife.

> *Years of midwives being subsumed by the hospital medical methodologies of patient care have taken away the image of midwives being able to practise in their own right. The doctors still have the ultimate responsibility for the patient care, so even if a midwife does make a blue it can become the doctor's blue rather than hers, because he has to take responsibility for patients admitted under his clinic. So all that is an area of confusion that hasn't been sorted out. But if the midwife took up her own responsibility and accountabilities, and could be sued the same as the medical staff, well, I think things might change.*

Other controlling aspects of medical domination included the restriction on midwives from obtaining a provider number. Without a provider number midwives' clients were not entitled to claim rebates through Medicare. Reimbursement of costs through private health insurance companies was not readily available to women. This was seen by midwives as a financial disincentive for women to choose a midwife as her primary care provider. Retention of control over the ordering of pathology tests was seen to be farcical by midwives who routinely filled in order forms for doctors to sign en masse. Prescribing rights for any medications were also withheld from midwives.

7.7.3 Unnecessary medical intervention

Levels of unnecessary medical intervention were influenced through relationships between the major categories of practice settings, consumer awareness and nursing/midwifery integration. Midwives in private hospital settings spoke of the influence of the expectations of consumers on the obstetricians' use of medical intervention during pregnancy and childbirth. Midwives practising in level 2 and level 3 hospital settings in metropolitan areas spoke of the *unnecessarily high* levels of

intervention, linked again with consumer expectations. Midwives spoke of themselves as specialised nurses within these *high tech* settings.

The subsuming dimension of unnecessary medical intervention on the midwife's practice was the development of specialised nursing skills practised under the control of obstetricians, through organisational policies and procedures. Clinical practices and decision making were dictated by rigid adherence to these policies and procedures. Ability to practise at a high level of competency within highly technological and medicalised environments required midwives to have deeply ingrained knowledge of organisational policies and procedures and each obstetricians' practice requirements for specific procedures. This focus on the technical needs of the obstetrician to implement unnecessary medical interventions was seen by midwives to detract from supportive, women focused care. It also contributed to hospital staffing methodologies where *core staff* were retained in a specific practice area to ensure medical practitioners needs were catered for.

Midwives were strongly supportive of the use of medical intervention where it was considered to be for the well being of the women and their babies. Midwives were also aware of the pressures upon the obstetricians to meet the expectations of the women and their families, and to achieve favourable outcomes. They were also cognisant of women's choices in pregnancy and childbirth, while expressing concern regarding women's access to a full range of informed choice. This was articulated well by a community women's health educator who also worked as a midwife in private practice. She stated:

> *I think open communication with the women and their families is what choices are about. I think that has been the difference between why midwives historically have not been sued by the women, and the doctors have. With midwives* (in private practice implied) *there is really open communication going on there, and I think that we are providing a customer service, and it's up to us to actually say to customers, look, this is who I am and these are the types of things I do, and let them make the choices. I mean, I think sometimes it's a bit more like the information is given from above - "and you be good and I will look after you". And it's*

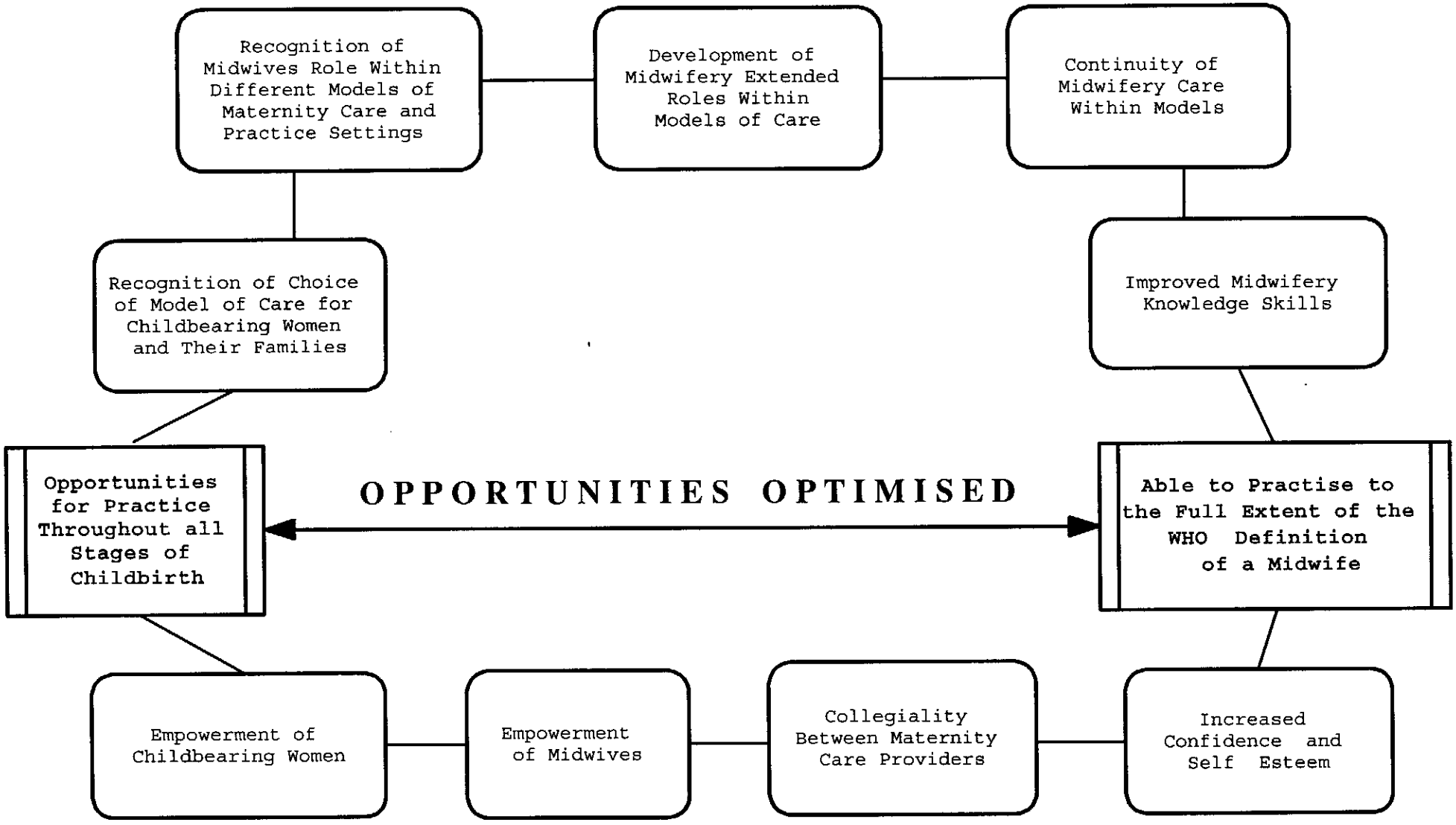
like "you don't have to worry about it", whereas I think there should be a real sharing of information that takes place before choices are made.

Midwives working in hospital settings displayed ambivalent behaviours towards what they categorised as unnecessary medical intervention. In the antenatal care settings midwives had specialised in performing ultrasound and cardiotocograph procedures. Such procedures were often performed routinely and not questioned by midwives. The main concern was that medical policies and procedures or direct medical orders were followed. During intrapartum care midwives specialised in this aspect of maternity services were also practising routine medical interventions following established policies and procedures.

The effects of these practices have been demonstrated throughout these findings as they infiltrated practice settings and culminated in fragmented midwifery care controlled by medically focused obstetric policies and procedures. Midwives actions/interactions within practice settings demonstrated ambivalence towards medical intervention in normal pregnancy and childbirth. This ambivalence towards their own role contributed to a perceived lack of recognition of the midwife's role by the medical profession.

7.7.4 Recognition of the midwives' role by the medical profession

Individual interactions, between midwives and medical professionals, determined their perceptions of the effect the recognition of their role by the doctors had on their ability to practise throughout all stages of childbirth. Where midwives felt their knowledge and skills were acknowledged as adequate to practise to the full extent of the WHO Definition of a Midwife, they were able to optimise their practice opportunities by developing collegiate relationships with medical practitioners. Where midwives felt their practice was subordinate to the medical profession, their opportunities to practise to the full extent of the midwife's role were limited by rigid routines within each segment of maternity service delivery. Lack of recognition of their role as holistic midwifery practitioners was the ultimate consequence of the medical subsumption of midwifery.



Schema 3 Consequences Of Optimising Actions/Interactions

The personalised impact of both lack of recognition, and full recognition, was portrayed by an English midwife as she struggled through adjusting to the *medicalised* Australian maternity services.

> *Having a baby is a normal situation and I couldn't believe that women could be treated in such a different way. To me it wasn't midwifery it was verging on the point of being barbaric. Women were not treated as women. They were treated like pieces of meat on the table. I saw more traumatic deliveries in a few months than I had seen throughout all my years of practice in the UK. The numbers of episiotomies and Caesarean sections were much higher, especially for such a small unit. I had worked in units like this that had been run by midwives, and the midwives had control- and we had normal deliveries. I found it very frightening. The GPs didn't seem to be as highly trained as the English midwives were. In my opinion they made a lot of mistakes and some were actually dangerous. I kept wanting to talk about what I thought midwifery was supposed to be but the midwives just thought I had a chip on my shoulder.*

This English midwife went on to defend her viewpoint:

> *I don't believe I have. I feel very empathetic towards the women. I treat everything as normal until proven otherwise, and that is when I believe a medical practitioner should be brought into the situation. ...*
>
> *I managed to complete a four and a half year apprenticeship here! It did me good. The midwives' practices changed during that time. They started encouraging women to be more active during labour, and they became more accepting of the alternative beliefs of women, because most women do want to have a normal birth. I don't believe I am an alternative midwife or a radical midwife- I just work for women and give them what they want. Then at the end of the day if they have to have a forceps delivery, or a vacuum extraction, or a Caesarean, they know that they've done their best. After I've looked after a woman in labour I hope that they never have to feel they've failed.*

She further elaborated on the transition:

Table 68 **Stages of Optimising Holistic Practice Opportunities Within Contextual Categories.**

Contextual Category	Optimising Stage	Optimising Actions / Interactions	Consequences
Consumer Awareness Practice Settings	Stage One - Revealing the Image Stage Two - Influencing Decision Making	• providing information • acceptance of a wellness focus • facilitating birthing choices • involving women and families • respecting social and cultural preferences • available within all models of care • marketing the role of the midwife • demonstrating competencies throughout antenatal, intrapartum and postnatal care • demonstrating effective interpersonal communication behaviours: getting to know the women developing trust, demonstrating sensitivity, listening, empathising, encouraging, supporting, advocating, teaching, debriefing **Pre-requisite - Continuation of Stage One** • working collaboratively with consumer organisations • advocating articulately for consumers • advocating culturally appropriate services • empowering women to make choices and maintain control of their pregnancy and birthing experience • developing collegiate relationships amongst health service providers • focusing on achieving desirable outcomes within all models of maternity care • implementing recommendations from birth reviews • involvement in planning and setting up services • participating in the development of organisational policies and procedures	Consumers needs and expectations met. ↕ Recognition of the role of the Midwife ↕ Holistic midwifery care available within all practice settings ↕ Continuity of care and carers available within all models of maternity service provisions

Table 68 (continued)

Stages of Optimising Holistic Practice Opportunities Within Contextual Categories.

Contextual Category	Optimising Stage	Optimising Actions / Interactions	Consequences
Medical Subsumption	Stage Three - Changing The Paradigm	**Prerequisite - Continuation of Stages One and Two** • promoting a health oriented approach to childbirth • empowering women to give birth, rather than "be delivered" • maintaining collaborative relationships with medical practitioners • developing interdependent relationships amongst maternity care providers • demonstrating advanced clinical competencies • accepting responsibility and accountability for clinical decisions and their outcomes	Midwives prepared for autonomous practice ↕ Increased focus on a health oriented giving birth midwifery model of care
Nursing / Midwifery Integration	Stage Four - Expanding the Profession	**Prerequisite - Continuation of Stages One, Two and Three** • implementing the midwifery model • establishing and controlling midwifery policies • recognising the role of the A.C.M.I. • actively participating in national and state branch A.C.M.I. activities • developing and implementing holistic curricula • achieving competencies based on A.C.M.I. standards • developing theory through research • implementing research findings	↕ Midwives meeting the Standards for the Practice of Midwifery ↕ Australian Midwives able to practise according to the International Definition of a Midwife (WHO, 1976).

During this time I also managed to get on with the doctors and I think I proved to them that I had the skills to be able to care for their labouring, and antenatal women. So much so that now I've got consultant back up for home confinements which I do, not regularly but just enough to keep my hand in. I try and integrate a home confinement with the skills I've developed in the hospital. There is no lackadaisical attitude to my home confinements, no alternative methods of medication. They all have the standard syntocinon or syntometrine after delivery. They all receive Vitamin K. I feel the doctors have learned to trust me and I'm happy that they are willing to provide consultant back up for me. I would go so far as to say, I think it shows they are maturing and they are not being selfish about their obstetrics. I do think Australian obstetrics is getting better. The trauma is less, although I do think inductions are statistically higher than elsewhere because there are still a lot of social inductions in this country that never happened in the UK, and social Caesareans as well. But I do think doctors are allowing midwives to do normal deliveries more now than they were.

The development of confidence and trust in the abilities of the midwives to provide holistic care that met the needs of childbearing families was evident throughout the interviews with midwives. It was the consequence of optimising behaviours and interactions between midwives, medical practitioners, and the women receiving their care. It was epitomised by collegiality between health professionals as they recognised and respected each other's role and contribution towards consumer focused maternity services.

7.8 The core process - optimising holistic midwifery practice opportunities

The consequence of integrated action/interactions between midwives and other maternity service providers was empowerment of the midwives to provide consumer focused care (illustrated in Schema 3 p.266). These integrated, empowering actions and interactions were the key elements of the process *optimising holistic midwifery practice opportunities.*

The process of optimising holistic midwifery practice opportunities linked together the concepts of continuity of care for the consumer and holistic practice for the midwife. The midwife's role in providing care throughout the antenatal, intrapartum and postnatal continuum, within models of maternity services was recognised. The findings of this case study on the Australian midwives' practice domain demonstrate four stages of optimising, within the conceptual categories of *consumer awareness, practice settings, medical subsumption, and nursing/midwifery integration.* These optimising actions and interactions were evident throughout contextual sub categories. There was a linking together of stages of optimising and specific categories. Stage one of the optimising process, *revealing the image,* was linked with *consumer awareness.* Stage two was identified within *practice settings* as *influencing decision making.* Stage three, *changing the paradigm,* related to the context of *medical subsumption,* while stage four was identified as *expanding the profession,* within the context of *nursing/midwifery integration.* Table 68 (pp. 268-269) illustrates the optimising actions and interactions as they were identified within stages of a continuous optimising process, and within conceptual categories. The consequences of optimisation are also depicted.

7.8.1 Revealing the image - stage one of optimising opportunities for holistic practice

Lack of recognition of the midwives' ability to practise to the requirements of the WHO *Definition of a Midwife* was the core consequence of limitation of opportunities to practise throughout all stages of childbirth. Where holistic practice opportunities were available midwives were able to demonstrate optimising actions and interactions that revealed the dimensions of their interdependent, holistic role, as reflected in the WHO Definition of a Midwife.

Within the contextual categories contributing towards the opportunities to practise throughout all stages of childbirth there were dimensions of revealing actions/interactions. This stage of optimising, classified as *revealing the image,* is discussed within the category of *consumer awareness.*

Midwives referred to the image presented to consumers as being *unable to act as autonomous providers of maternity care.* Limiting actions and disempowering

interactions veiling consumers' perceptions of the role of the midwife in providing maternity care were identified as: failure to provide information on the role of the midwife within different models of care available to the childbearing woman and her family; low level participation in the development of policies and procedures controlling midwifery practice; acceptance of the medical model as the dominant philosophical approach to midwifery practice, and subsuming interactions with the medical profession. Optimising actions and empowering interactions identified as revealing the role of the midwife to the consumer included: sharing information, providing continuity of care, teaching, facilitating birthing choices, getting to know the woman, involving the woman and her family in planning for the birth, respecting social and cultural preferences, encouraging, supporting, empathising, advocating, listening, developing trust, demonstrating sensitivity, debriefing, and being available within all models of care.

Throughout analysis of the actions/interactions of midwives in revealing their role to the consumer both optimising and limiting actions/interactions were evident. Where midwives provided women with information regarding their choices of models of service and the role of the midwife within each model, consumers' image of the midwife was optimised. Withholding this information limited revelation of the role of the midwife, and consequently the recognition of the role by consumers. As midwives provided care that met consumers' expectations, throughout all stages of childbirth, they revealed the role of the midwife within the maternity care team. Competencies were revealed as midwives demonstrated the required knowledge and skills throughout antenatal, intrapartum and postnatal care. Where midwives were not available, or visible, within the model of service delivery chosen by the women, a limited image of the midwife's role was portrayed and women and their families did not recognise the holistic role of the midwife as an interdependent practitioner in the maternity care team. Consequently midwives were limited in their ability to influence decision making in the provision of maternity care to these women and their families.

7.8.2 Influencing decision making - stage two of optimising opportunities for holistic midwifery practice

Fieldwork visits to practice settings throughout the three representative states revealed a wide range in the level of involvement of midwives in decision making regarding their

practice and the midwifery care they provided. Actions/interactions taken by midwives to influence decision making demonstrated a continuum ranging from no influence to highly influential. A requirement for influence in decision making was stage one of optimising opportunities for holistic midwifery practice; the revelation of the image of the midwife as an interdependent practitioner in the maternity care team within each specific practice setting.

Within the context of the effect of practice settings on midwives' opportunities for holistic practice contributing sub categories were identified as: geographic factors; public and private health care settings; organisational structures and levels of service delivery; and models of service delivery. Actions/interactions identified as influencing decision making within these sub categories included: advocating culturally appropriate services; working collaboratively with consumer organisations; advocating articulately for consumers; empowering women to make choices and maintain control of their pregnancy and birthing experiences; developing collegiate relationships amongst health service providers; focusing on achieving desirable outcomes within all models of maternity care; involvement in planning and setting up services; implementing recommendations from birthing reviews, and participation in the development of organisational policies and procedures. As midwives revealed their role as interdependent practitioners within the various models of service delivery, they were able to influence decision making regarding the delivery of maternity care. This provided opportunity to contribute towards changing the established paradigm, based on the medical model, to a more social model reflecting the consumers' expressed preferences for choice and continuity of care and carer.

7.8.3 Changing the paradigm - stage three of optimising opportunities for holistic midwifery practice

The categories of practice settings and medical subsumption were interlinked through the dominance of the medical model as the paradigm for maternity service provision. References were made continuously to the subsumption of midwifery practice under the all encompassing umbrella of the medical model, and its impact on every aspect of midwifery care within all models and throughout all settings. The medical model was perceived by midwives to focus on sickness rather than wellness, with abnormal rather

than normal processes affecting the outcomes of pregnancy and childbirth. The dominance of the model was also considered by midwives to have contributed to a state of medical dependency demonstrated by both consumers and midwives.

Midwives referred to what they described as two diametrically opposed models of maternity service provision i.e. the medical model as opposed to the natural model. It was evident from the data that this terminology did not have a common meaning for those making reference to the models, although there were obvious properties that could be mutually exclusive. What midwives perceived to be *unnecessary medical intervention* was relegated to the medical model, while interventions that were considered to result in a vaginal birth without extensive physical trauma may well have been accepted as belonging to the natural model. Interventions such as ultrasound, electronic fetal heart rate monitoring, intravenous therapy, syntocinon administration, and administration of analgesic gases were referred to within the context of natural (or normal) birth, rather than as products of the medical model.

This ambivalence by midwives towards these opposing models reflected a polarisation of views. Where midwives demonstrated actions/interactions optimising holistic practice opportunities, within each setting of maternity service provision, there was an increased focus towards the health orientated/giving birth model. These midwives demonstrated stage one of the optimising process, revealing the image of the midwife to consumers, and stage two, influencing decision making within the practice setting. Stage three, changing the paradigm from the subsuming medical model was a continuation of the optimising holistic practice opportunities process.

Failure to recognise pregnancy, labour and birthing as normal physiological processes, where women gave birth to their babies supported by competent knowledgable midwives, was considered to contribute to the high unnecessary intervention rates. Midwives also referred to *convenience obstetrics* where obstetricians actively managed labour around their own time tables rather than the needs of the mother.

Australian midwives expressed their perception that the dominant medical model has successfully propagated the concept that birth is only normal (and safe) in hindsight, rather than every pregnancy considered as normal unless there are indications that something is wrong (Savage, 1986). Bennett et al. (1993) suggest that the

medical versus natural dichotomy does not reflect the continuum of views held by the majority of women. Rather, they speak of a risk orientated/health orientated dimension and a being delivered/giving birth dimension. Combining these two dimensions gives four distinct models that reflect the underlying assumptions of models of service identified and discussed throughout the findings of this present study. These models have been identified as: risk orientated/being delivered; health oriented/being delivered; risk orientated/giving birth; and health orientated/giving birth. These models provide an alternative paradigm within which the models of service described in this study as; the specialist obstetrician care model; the general practitioner care model; the birth centre model; the alternative birthing suite model; and the domiciliary midwifery care model, can be discussed.

Risk orientated/being delivered model

Within the dimensions of a risk orientated/being delivered medical model midwives were limited in their role as holistic practitioners. Their actions/interactions were dictated by unit policies and procedures. Optimising interactions were still evident to a limited degree. Midwives spoke of the interdependent relationships they had developed with the specialist obstetricians. Where obstetricians recognised the midwife's knowledge and skills they often encouraged midwives to attend to the women in normal labour, referring to the obstetrician when birth was imminent. Collegiate relationships had been developed within the specialist obstetrician model of care and collaboration occurred between members of the maternity team. Midwives working within the dimensions of a high risk/being delivered specialist obstetrician model practised as specialised obstetric nurses, providing a level of technological expertise essential to the safe performance of medical interventions within these risk orientated settings.

Health orientated/being delivered model

A health orientated dimension did not exclude the risk factors involved in pregnancy and childbirth but maternity care providers were more likely to consider mother and babies as healthy unless there were indications to the contrary. There was an emphasis on normal physiological processes and medical intervention was not routinely

implemented. Women were encouraged to be involved in the planning and conduct of their delivery, but midwives and medical practitioners controlled the environment and unit policies and procedures dictated decision making. Labour wards in level one and smaller level two organisations were the settings where the health orientated/being delivered model was the predominant paradigm for midwifery practice within the General Practitioner Hospital Care Model.

This model of care provided midwives with opportunities to optimise their holistic midwifery practice. Smaller obstetric units were usually in country or small town settings, or in the outer suburban areas. Midwives revealed their image through their participation in community events and associations and relationships were developed between midwives and consumers as mothers returned to their local hospitals for the birth of subsequent children. Midwives were also influential in decision making processes as they involved themselves in the development of policies and procedures that were approved through local hospital medical advisory committees and hospital management.

Building collegiate relationships with medical practitioners based on mutual trust resulted in a collaborative approach to the care of women and babies. Trust was seen as the essential element of these practice optimising relationships. Where midwives considered the medical practitioner to be lacking in midwifery knowledge and skills there was a reluctance to work collaboratively. This was demonstrated by midwives delaying the call to alert the medical practitioner that birth was imminent, increasing the likelihood that the baby would be born before the arrival of the doctor. During interviews midwives suggested that this was an unspoken but mutually convenient practice where medical practitioners lacked confidence and skills. Conversely, where medical practitioners lacked trust in the midwives, they exercised their perceived hierarchial status and limited midwives opportunities to practise as interdependent practitioners.

Failure to resolve deeply entrenched issues affecting the relationships between midwives and general practitioners limited optimisation of midwives' practice within the health orientated/being delivered dimensions of midwifery care. There was a duplication of services offered by these two groups of professionals, and with the increased involvement of specialist obstetricians in normal pregnancy and childbirth,

there was a triplication of professional services within health orientated/being delivered dimensions of care.

The models of care recommended by the Joint Birth Consultative Committee (1992) fail to acknowledge this triplication of services to women choosing specialist obstetrician care, general practitioner care or shared care. Changing the paradigm to reflect the dimension of health orientation rather than risk orientation requires the counter balance of the parallel dimensions of being delivered and giving birth. Optimising actions/interactions demonstrated by midwives towards changing the dominant, subsuming medical model included promoting the health orientated dimension and moving from the dimension of being delivered to giving birth.

Risk orientated/giving birth model

The combining of the risk dimension with the giving birth concept reflected the influence of the medical model's *birth is only normal in retrospect* philosophy. Women were encouraged to actively manage their own birthing experience providing they met the criteria to be designated *low risk.* Practice settings providing these models of care included hospital units (where the prevailing philosophy was towards natural childbirth), labour rooms that had alternative birthing suite philosophies, and birth centres. These were models where midwives perceived themselves to be interdependent practitioners, recognised by consumers and medical and nursing/midwifery colleagues as the providers of midwifery care for women expected to have a normal birthing experience. They were involved in the development of policies and procedures that reflected their philosophy of supporting women to give birth to their baby rather than be delivered by health professionals. Opportunities to practise throughout all stages of pregnancy and childbirth, and optimisation of holistic care opportunities for low risk women, were enhanced within this model. Women deemed to be high risk were excluded from this dimension of midwifery care.

The effect of the risk orientation dimension within these models of care on the midwives' holistic practice opportunities has been discussed in birth centre reviews and studies. The generally accepted philosophy within these settings is that pregnant women with a low risk of complications can be selected by a doctor for total midwifery care by a team of midwives. The midwives' aim is to provide a non interventionist approach for

uncomplicated pregnancies, with ready access to obstetrical and paediatric assistance if complications are detected. Women, and midwives, have the reassurance of rapid medical intervention should there be any deviation from the normal. There are recognised risk indicators guiding and controlling practices within these models of care.

In this case study of Australian midwives those providing models of care that were incorporated into the risk orientation/giving birth dimensions did not consider themselves subsumed by the medical model. They were highly satisfied with their opportunities to practise holistic midwifery care and were proud of the outcomes for mothers and babies within their units. Concern was expressed about high transfer rates. This was particularly so in birth centres adhering to stringent exclusion criteria where women who were transferred out of the birth centre program progressed through their birthing experience without any adverse outcomes. It was also evident during field visits that collaborative approaches to care between midwives and medical practitioners could contribute to improved retention rates. Statistical data from one birth centre where medical consultation within the birth centre was not permitted indicated that 80.2% of the women transferred out of the birth centre went on to have a normal vaginal delivery.

As demonstrated throughout this study midwives' opportunities to practise within this health orientated/giving birth dimension were frequently limited through the four major identified categories of consumer awareness, practice settings, medical subsumption and nursing/midwifery integration.

Health orientated/giving birth model

Optimising action/interactions were taken by midwives within all settings, to provide holistic care, however, this was only fully possible within the health orientated/giving birth dimensions. Midwives providing care within this model succeeded in changing the paradigm from a subsuming medical model to a more united medical/social approach, increasing opportunities to provide continuity of midwifery care within various models of maternity service delivery. Domiciliary settings liberated women and their families to take control of their birthing experiences and to choose their birth attendant. Birth was considered a normal physiological event. It was recognised that complications do occur but the focus was on healthy pregnancy culminating in the birth of a healthy baby. Midwives were able to provide the health orientated/giving birth

dimensions of midwifery care in any setting where it was accepted as the dominant philosophy. It was most clearly demonstrated by midwives in private practice, and within birth centres and maternity units where the birth plans of women desiring this dimension of care were adhered to.

This approach to pregnancy and childbirth often received opposition from health professionals, including midwives. An anomaly was apparent. The health orientation dimension was accepted by midwives in the context of the health orientation/being delivered dimensions but there was opposition expressed towards the health orientation/giving birth dimensions. The difference was the question of responsibility. The being delivered dimension allowed control to remain with the health professionals. This was accepted within the safety net of the recognised health care system. To move beyond this was to accept the legal liabilities associated with childbirth, from which the midwife is protected when following policies and procedures laid down by the employing organisations. The consumer is also protected within the organisational structures. In the event of mother or baby suffering harm it becomes the medical practitioners or the service providing organisations that are challenged. Midwives participating in the study acknowledged their hesitation in accepting this level of accountability for their practice, and they expressed opinions that the profession as a whole was ill equipped to perform at this level of autonomy. These findings suggest that the Australian midwifery profession must consider its preparedness to practise within a changing paradigm before advancing on to the fourth stage of optimising practice opportunities - expanding the midwifery profession.

7.8.4 Expanding the profession - stage four of optimising opportunities for holistic midwifery practice.

This stage of optimising opportunities to practise throughout all stages of pregnancy and childbirth was linked to the conceptual category of *nursing/midwifery integration.* The recognition, by nurses and midwives, of the role of the midwife in providing holistic midwifery care was essential for midwives to optimise their opportunities to practise throughout all stages of childbirth. Contextual sub categories within nursing/midwifery integration affecting opportunities to practise throughout all stages of childbirth were identified as: specialisation; multi skilling; education; policies and procedures, and

legislation. Consequential sub categories were identified as: lack of continuity of care; lack of recognition of the midwife's role; and obstetric nurse practitioners. These sub categories were the outcomes of limiting actions/interactions occurring within the contextual subcategories of: specialisation; multi-skilling; education; policies, procedures and legislation.

Optimising actions/interactions demonstrated by midwives within this fourth stage of the process of optimisation of opportunities for holistic midwifery practice contributed to the expansion of the midwifery profession at individual practitioner level, and at the level of the Australian midwifery profession. Where midwives practised within settings providing the health orientated/giving birth dimensions of midwifery care they were able to practise holistic midwifery, providing continuity of care within a midwifery model of care. Midwives practising within models emphasising the risk orientated/being delivered dimensions of care practised as obstetric nurses guided by the medical model and the nursing process, problem solving approach to assessing, planning, implementing and evaluating patient care. This resulted in fragmented procedural care instead of a holistic, family centred continuing model of care.

Midwives practising within the medical model spoke of developing extended roles. This involved gaining advanced clinical competencies in performing specific obstetrical or neonatal tasks e.g. insertion of intravenous cannulas, suturing techniques, fetal scalp electrode monitoring, assessment of blood gases, etcetera. Midwives extending their role through developing technical expertise in specialised settings, e.g. neonatal care, delivery suite, high risk antenatal monitoring etc. became clinically expert in these areas of practice, rather than developing as holistic midwifery practitioners within the midwifery model of care.

Throughout fieldwork visits and interviews with midwives in the diverse practice settings midwives were seen to be expanding their opportunities to practise throughout all stages of childbirth. Models of care demonstrating the dimensions of health oriented/giving birth characterising the midwifery model had been introduced to optimise holistic practice for the midwives, and the provision of continuity of care for the childbearing women and their families. These models included; rotation of teams of midwives throughout practice areas; team midwifery; know your midwife schemes; birth centre and domiciliary models of care.

7.9 Optimising holistic midwifery practice opportunities - a conceptual paradigm

The conceptual paradigm developed from the analysis of data from the in-depth interviews and fieldwork observations is illustrated in Schema One (p.198). The core problem affecting midwives' ability to practise to the full extent of the internationally accepted definition of a midwife was their failure to optimise opportunities to practise throughout all stages of childbirth. The core category emerging from the data was *opportunities to practise throughout all stages of childbirth*. The dimensions of this category extended on a continuum from opportunities being fully limited to opportunities being fully available. Four contextual categories were defined from the data contributing to the core category. These were nominated as; consumers; practice settings; the medical profession; and the nursing/midwifery professions. Sub categories contributing to the contextual categories were identified and described within the context of their occurrence and their contribution to the core category, *opportunities to practise throughout all stages of childbirth* (Schema 2 p. 200).

The core process affecting midwives ability to practise to the full extent of the international definition of a midwife was *optimising opportunities for holistic midwifery practice.* The process of optimising occurred in four stages that were continuous throughout optimising, but demonstrated pre-requisite characteristics before progression to the next stage. These pre-requisite qualities were linked to the four major theoretical constructs emerging from the contextual categories. These were described as; *consumer awareness; practice settings; medical subsumption;* and *nursing/midwifery integration* (Table 68 pp. 268-269).

Within the theoretical construct of *consumer awareness* the pre-requisite stage of optimising holistic midwifery practice opportunities was nominated *revealing the image.* Optimising actions/interactions of midwives revealed their role to the consumer by establishing the value of the services provided by midwives to childbearing women and their families. Recognition of the midwife's role by the consumer was the consequence of this first stage of optimisation.

The second stage of optimising opportunities for holistic practice opportunities was described as *influencing decision making.* This stage occurred within the context of practice settings and models of practice within settings. Actions/interactions

influencing decision making were identified and their consequences for limiting or optimising opportunities to practise throughout all stages of childbirth discussed.

Changing the paradigm from a medical model to a midwifery model of care was the third stage of optimising. This was identified within the theoretical construct of *medical subsumption.* Midwives optimised their opportunities to practise throughout all stages of childbirth through the midwifery model with its emphasis on the dimensions of health oriented/giving birth concepts. Failure to change the paradigm from the dominant medical model with its risk oriented/being delivered dimensions resulted in midwives providing fragmented obstetrical care to women and their families, rather than continuity of care throughout pregnancy, childbirth and early parenting.

The final stage of optimising opportunities for holistic midwifery practice was *expanding the profession* within the context of *nursing/midwifery integration.* As a profession midwifery continues to be subsumed by the nursing profession. The integration of the two professions was demonstrated as being deeply entrenched and its limiting effect often unrecognised by midwives.

Optimising actions/interactions taken by midwives throughout diverse practice settings and across all models of maternity service provision resulted in midwives being able to practise to the full extent of the *International Definition of a Midwife* (WHO, 1976) and to practise according to the *Standards for the Practice of Midwifery* (ACMI, 1989). Limiting actions/interactions resulted in midwives practising as obstetric nurses providing fragmented care to the women and neonates. These obstetric nurses were often specialised in particular areas of obstetric or neonatal care, providing advanced clinical expertise as specialised nurses but not practising within a health oriented/giving birth midwifery model. Failure to recognise the pre-requisite characteristics of the four stages of optimising holistic midwifery practice opportunities resulted in midwives being unable to meet the *Standards for the Practice of Midwifery* (ACMI, 1989) based on the *International Definition of a Midwife* (WHO, 1976).

CHAPTER EIGHT

DISCUSSION AND CONCLUSION

8.1 Introduction

The purpose of this study was to identify the actual domain of midwifery practice in Australia according to the *Standards for the Practice of Midwifery* (ACMI, 1989), and to determine and explain those factors affecting the full potential role of the midwife. To achieve this purpose four research questions were formulated. The first three questions were addressed in Chapters Four, Five and Six. Chapter Four provided the descriptive data identifying the actual role of the midwife in providing obstetric and neonatal care. The discrepancies between the actual role and the ACMI's stated sphere of practice, based on the International Definition of a Midwife (WHO, 1976), were quantified in Chapter Five. The facilitators and barriers to the enactment of the full potential role, and ratings of their perceived importance, were presented with supporting comments from midwives in Chapter Six.

To address the fourth research question regarding the action/interaction taken by midwives to enable them to practise to the full extent of their defined role, Chapter Seven used a story line presentation. A conceptual paradigm (Schema 1, p.198) developed through a grounded theory approach to the analysis of qualitative data from 75 purposively and theoretically sampled midwife interviewees, was used to order and present the story line discussion.

This final chapter combines the findings of the previous chapters for discussion using the conceptual paradigm as a framework. The quantitative findings from the randomly selected survey sample (n=1754) provide a measure of generalisability to the qualitative findings from the interviews. Comparisons are also made between the survey sample (n=1754) and the interview group. This comparative data was made available by 53 of the 75 interviewed midwives completing the same questionnaire as the randomly selected midwives.

As the findings are summarised they are compared with previous research on the role of the midwife. The implications for Australian midwifery practice are discussed, and recommendations made for further research into the practice domain of Australian midwives.

8.2 Lack of recognition of the role of the Australian midwife

Increased recognition of the knowledge and skills of the midwife by consumers, the medical profession and the nursing/midwifery professions, was rated by 82% (1438) of midwives participating in the survey as an *important* or *essential* factor to enable them to practise according to the *WHO Definition of a Midwife.* There were 0.5% who gave a rating of *not important.* The expressed levels of satisfaction with the level of recognition of their knowledge and skills to meet the requirements of the *WHO Definition of a Midwife* had a majority medial response of *mostly satisfied* with a strong bias towards *little* or *no satisfaction* rather than *well* or *highly satisfied* (see Table 63 p. 101).

The descriptive data presented in Chapter Four provided a profile of Australian midwives. Facets of this profile are highlighted in this summary of the findings, and their relevance to the practice domain of Australian midwives is demonstrated. The demographic data identified that 864 of the 1753 midwives taking part in the survey had not practised during the past five years. This indicated that nearly half (49.2%) of midwives currently registered to practise within the states of New South Wales, Victoria and Western Australia had not been employed as midwives for five years or more. Further to this, 235 (13.4%) had never practised following registration as a midwife. Of those midwives responding to the question of whether or not they had been employed in positions (other than as a midwife) where their midwifery knowledge and skills had been utilised, there were 646 who referred to nursing positions.

These findings confirm the wastage of midwives to general nursing identified as early as 1978 through the National Survey of Nursing Personnel; re-affirmed by Barclay (1984) and the Health Department Victoria Policy and Planning Unit (1993). Concern with the low retention rate of midwives, and the current registration of midwives having not practised for over five years, prompted the recommendations made in a report, based on this present study, to the Commonwealth Department of Human Services and Health (Cullen and Martins, 1996). It was recommended that:

> *A national register should be maintained for all states by the Australian College of Midwives in cooperation with the Nurses Boards of each state.*
>
> *There should be uniformity of criteria across states for continuing registration. The maximum period of 5 years without practising as*

preclusion to registration is recommended.

Retention of midwives following completion of a midwifery course should be monitored through registering authorities to identify trends in high attrition rates.

Selection criteria for admittance to a course of midwifery should include an expectation to practise as a midwife.

Midwives who have not practised for 5 years should be required to undertake an approved refresher course to maintain registration and obtain a current practising certificate (Cullen and Martins, 1996 p. 111).

The integration of the nursing and midwifery professions was evident in the findings on joint membership with professional nursing and midwifery colleges and associations. There were 44.5% of the midwives surveyed who nominated membership with the Australian Nursing Federation (ANF), compared to 13.6% who stated they were members of the Australian College of Midwives Incorporated (ACMI). Of importance to this study is the comparison between membership status of the randomly selected sample of midwives and midwife interviewees who were purposely selected. The interview group showed higher membership percentages in both the ANF and the ACMI. There was a 71.7% membership status with both the ANF and the ACMI amongst the interview group.

This finding is of significance to this present study and to previous research on the role of the Australian midwife. It is evident from the findings of this study that there is a wide range in the level of participation in professional activities between midwives. Throughout this study the responses from the interviewed group of midwives, to the survey questionnaire, have been presented separate from the randomly selected survey sample findings. The different responses from the two groups indicate that the prevalence of optimising actions/interactions demonstrated by the interviewed midwives, cannot be generalised to the randomly selected sample group of midwives. The differences between the two groups are graphically illustrated in figures 5 and 6 (p. 72) showing the much greater percentage of interviewed midwives who had completed tertiary degrees and nursing post graduate qualifications. As demonstrated in Table 50 (p.147) this selected group of midwives were also more involved in professional development activities aimed at maintaining and developing midwifery knowledge and skills.

The possible bias to studies presenting midwives' views on their education and practice if selection of subjects is restricted to, or monopolised by members of the ACMI, has been acknowledged by Barclay (1986) and The Midwifery Working Party - South Australia (1991). The findings of this study demonstrated significant differences in ratings of importance for specific factors affecting their practice, given by employed midwives who were members of the ACMI, to the ratings given by employed non members of the College. On this basis the recommendation made in the report to the Commonwealth Department of Human Services and Health (Cullen and Martins, 1996 p. 164) was that:

> *with ACMI membership less than 15% of midwives registered to practise throughout the selected states for the study (New South Wales, Victoria and Western Australia) consultation should be sought from midwives not currently members of the ACMI in regard to professional issues affecting midwives and nurses.*

It was also recommended that:

> *Communication be established between the ACMI and the larger component of midwives practising throughout Australia. This could be achieved through the Australian Nursing Federation with its considerably higher midwifery membership of 44% from the same randomly selected sample of midwives.*

This communication with non ACMI members is essential to the future development and growth of the College. Midwives in practice settings throughout New South Wales, Victoria and Western Australia spoke of the invisibility of the College, and its perceived irrelevance to their practice. Considering the achievements of the ACMI since its severance as a special interest group of the Royal Australian Nursing Federation in 1983, it is surprising that midwives have not recognised the importance of the role of the ACMI in achieving *greater recognition of what midwifery is and its potential to achieve better care for women through midwives gaining self-governance of their profession* (Peters, 1995).

With support from midwives practising throughout Australia the ACMI's professional and political strength could be enhanced in its continuing efforts to remove the limitations imposed on midwives' opportunities to provide holistic care, and to achieve recognition as interdependent practitioners within the maternity services.

Consultation between the professional nursing and midwifery colleges and associations should be the first initiative towards a marketing strategy focused on recognition of the midwife's role in providing improved maternity services to childbearing women and their families within their chosen models of care.

8.3 Revealing the role

Recognition of the role of the midwife was dependent on stage one of optimising holistic practice opportunities: revealing the image (Table 68 p.267). The pre-requisite for recognition was that consumers' needs and expectations would be met. The impact of consumer awareness of the role of the midwife on midwives' opportunities to practise throughout all stages of childbirth was discussed in Chapter Seven. Factors identified, through the survey questionnaire, as limiting consumers' recognition of the role of the midwife in providing care throughout all stages of childbirth reflected the categories identified through the qualitative analysis of the data from the in-depth interviews with midwives. These included; lack of opportunity for a variety of clinical practice; lack of staff development opportunities in country areas; and restrictions placed on midwives' practice by medical practitioners.

Comments made by the midwife consumers reflected the image portrayed through the repeated themes of other consumer studies. Factors identified, through the survey questionnaire, as limiting consumers' recognition of the role of the midwife in providing care throughout all stages of childbirth endorsed the categories identified through the qualitative analysis of the data from the in-depth interviews with midwives. The following aspects of midwifery practice rated by midwives (who had been consumers of maternity services during the past 12 months) as needing improvement were: availability of midwives 288 (41.7%); information giving by midwives 271 (39.2%) interpersonal skills of midwives 268 (38.8%); support given by midwives 199 (28.8%); care given by midwives, 180 (26%); and the competence of midwives, 161 (23.3%).

The importance of the findings from the survey of midwives who had been consumers of midwifery services during the past 12 months (from the time of receiving the survey during June - August, 1993), is the added insight provided to midwives' collective self image. This image, or self concept, presents as a mirror image of consumers' perceptions of midwives actions/interactions, thus reinforcing the

ambiguity surrounding the consumers' image of the role of the midwife as a practitioner of holistic maternity care. The implication of this limited self concept is its self fulfilling potential as stated by Haralambos and Holborn (1991 p. 15): *Actors tend to act in terms of their self concept. Thus if they are consistently defined as disreputable or respectable, servile or arrogant, they will tend to see themselves in this light and act accordingly.* A process of negotiation is referred to by these authors whereby definitions of individuals based on preconceptions which actors bring to interaction situations can be changed, and promotion of a desired image achieved.

Throughout analysis of the actions/interactions of midwives in revealing their role to the consumer both optimising and limiting *negotiations* were evident. Where midwives provided women with information regarding their choices of models of service and the role of the midwife within each maternity care model, consumers' image of the midwife was optimised. Withholding this information limited revelation of the role of the midwife, and consequently the recognition of the role by consumers. As midwives provided care that met consumers' expectations, throughout all stages of childbirth, they revealed the role of the midwife within the maternity care team. Competencies were revealed as midwives demonstrated the required knowledge and skills throughout antenatal, intrapartum and postnatal care. Where midwives were not available, or visible, within the model of service delivery chosen by the women, a limited image of the midwife's role was portrayed and women and their families did not recognise the holistic role of the midwife as an interdependent practitioner in the maternity care team.

8.4 Discrepancies between the ACMI stated sphere of practice and the actual role

Discrepancies between the actual role of the midwife in providing maternity care was correlated and determined against the *Standards for the Practice of Midwifery* (ACMI, 1989), as presented in Chapter Five. Lack of compliance with specific criteria relating to the standards was centred around four main issues. These were summarised as:

1. Lack of input to the formulation of policies and procedures controlling their practice;
2. The prevalence of fragmented procedural care of the women in preference to an holistic, family centred, continuing model of care;

3. The impact of medical and nursing models of care reflecting an illness focus and an emphasis on the abnormal;
4. A wide range as a profession in the perceived adequacy of current midwifery knowledge and skills to meet the requirements of holistic practice defined in the *Standards for the Practice of Midwifery* (ACMI, 1989).

Each of these issues will be discussed.

8.4.1 Lack of input by midwives to the formulation of policies and procedures controlling their practice

The adherence to policies and procedures demonstrated throughout the quantitative findings of the randomly selected survey sample of practising midwives (n=1754) indicated midwives most frequently performed actual tasks following organisational policies and procedures rather than making autonomous practice decisions.

The findings from the random survey sample indicated midwives perceived themselves to practise at different levels of decision making within different areas. There was a greater perception of autonomous decision making in providing postnatal and intrapartum care than in the provision of antenatal care. Midwives rated their most usual level of antenatal practice as *following policies and procedures* (39.54%) compared with *autonomous decision making* (15.36%) and *performed under direct or indirect supervision of a medical practitioner* (15.2%). In providing intrapartum care 37.9% performed *following policies and procedures* while *autonomous decision making* rated 23.5%, and *performed under direct or indirect medical supervision* 20.9%. Midwives providing postnatal care indicated they practised *following policies and procedures* most frequently (46.8%), and *autonomous decision making* was rated as 27.1%., with *direct or indirect supervision by a medical practitioner* rated as 12%.

In response to the questions relating to the level of input midwives perceived themselves to have in the development of policies and procedures guiding the practice of antenatal, intrapartum and postnatal care there was a uniform rating of 81% as having indirect, little or no input. Although midwives' assessment of their most usual level of performance was *following organisational policies and procedures* (to which 81% of midwives indicated they had little influence in determining), the majority of the randomly selected sample of midwives responding to the questionnaire were mostly

satisfied with the division of responsibility for antenatal (65.6%), intrapartum (76.2%), and postnatal (86.1%), care.

On examination of written organisational policies and procedures within practice settings the researcher observed that many of the tasks performed were not included within policy and procedure manuals, but midwives referred to the restrictions placed on their practice through these policies and procedures. It was evident that reference was being made to unwritten informal policy that was an integral component of midwives' decision making processes. These findings confirmed what Garcia and Garforth (1991) referred to as the *politics behind policy documents,* or the unwritten informal policies influencing midwives' practice. As in this study on Australian midwives, attitudes within practice settings reflected the basic philosophies of different obstetric units. Attitudes and philosophies concerning the care provided to childbearing women and their families, influenced the actions/interactions within different practice settings visited by the researcher in New South Wales, Victoria and Western Australia. Extracts from interviews with midwives included in Chapter Seven as explanatory findings reflect the ethos of these settings. Comments written by midwives in the open section of the questionnaire suggested that the level of decision making was often blurred between following policies and procedures and autonomous decision making. This suggests the integral nature of both written and unwritten policies and procedures on midwives' practices.

These findings can be compared with the English study on the role of the midwife undertaken in 1979 (Robinson, Golden and Bradley, 1983) when concern over the erosion of the role was at its height. It focused in particular on the degree of responsibility midwives were able to exercise for decision making. As with this present study, midwives were often unaware of their dependence on policies and procedures in decision making. There was evidence that midwives overestimated the extent to which they made decisions based on their own clinical judgment, and underestimated the extent to which they practised according to prevailing unit policies (Robinson and Thomson, 1989).

8.4.2 The prevalence of fragmented procedural care of the women in preference to a holistic, family centred, continuing model of care

Compounding the above anomaly was the importance rating given by these midwives

on the need for changes to organisational policies and procedures if midwives were to fulfil their potential role. There were 80.3% (1408) who rated changes as important or essential. The satisfaction ratings given with the effect of organisational policies and procedures on individual potential to practise holistic midwifery indicated that 49.4% (876) were mostly or well satisfied. The same trend to rate the importance factor higher than the level of dissatisfaction with the effect on their own practice was evident with opportunities to provide care throughout all stages of pregnancy and childbirth. The importance rating given for increased holistic practice opportunities by those midwives who had been employed during the past five years (EP5= 882) was 94.5% as important or essential, however, 52.7% said they were mostly, well, or highly satisfied with the effect of present opportunities on their own practice.

The studies conducted in England, Wales and Scotland during the 1980's on the role of the midwife and the effect of policies and procedures within different organisational settings and medical structures identified the same anomaly. Although midwives stated their practice was restricted there was not a correspondingly high level of expression of dissatisfaction (Robinson, 1989; Garcia and Garforth, 1991; Green, Kitzinger, and Coupland, 1994).

The findings of this present study suggest that although midwives recognise the importance of increased opportunities to practise throughout all stages of pregnancy and childbirth if they are to have the ability to practise to the full extent of the WHO Definition of a Midwife, the majority of Australian midwives are satisfied with the effect of fragmentation on their practice. This results in limiting actions/interactions in influencing decision making throughout practice settings and within models of maternity service provision. Optimising actions/interactions to influence decision making are demonstrated by midwives actively promoting practices within models of care that reflect the consumers' expressed desires for continuity of care and carer throughout pregnancy and childbirth.

8.4.3 The impact of medical and nursing models of care reflecting an illness focus and an emphasis on the abnormal

Throughout the findings of this study midwives referred to what they described as two diametrically opposed models of maternity service provision i.e. the medical model as opposed to the natural model. References were made continuously to the subsumption

of midwifery practice under the all encompassing umbrella of the medical model, and its impact on every aspect of midwifery care within all models and throughout all settings. The medical model was perceived by midwives to focus on sickness rather than wellness; abnormal rather than normal processes affecting the outcomes of pregnancy and childbirth. Nursing models were described as extensions of the medical model. The nursing process was not well utilised by midwives. There were 515 (58.4%) of the group of midwives who had practised during the past five years who indicated they did not use the problem solving nursing process. There were only 212 (24%) who had set family orientated goals in planning perinatal care.

Midwives participating in the random survey sample (n=1754) expressed their highest levels of dissatisfaction with factors affecting their ability to practise to the full extent of the WHO Definition of a Midwife as the *level of medical intervention* and *lack of recognition of the role of the midwife by the medical profession.* Amongst midwives who had practised during the past five years 51.2% (452) were dissatisfied with the effect of unnecessary medical intervention on their own practice, in comparison with 4.7% (42) who were well satisfied. A medial rating of *mostly satisfied* was given by 39.3% (347). Similar levels of dissatisfaction were demonstrated for the recognition of their knowledge and skills by the medical profession. A further breakdown of this group of midwives into those who were members or non-members of the ACMI indicated a statistically significant difference in their expressed levels of dissatisfaction. College members were more likely to be dissatisfied (chi-square likelihood ratio significance .001). They were also more likely (p=.0002) to be dissatisfied with the level of recognition of their knowledge and skills by the medical profession. These findings, coupled with the higher ratings given by ACMI member midwives for the WHO Definition of a Midwife as an ideal to aim for, suggest that these midwives had greater expectations of their sphere of practice, and consequently were more aware of the limiting effects of medical subsumption on their opportunities to practise holistic midwifery.

The dominance of the medical model was also considered by midwives to have contributed to a state of medical dependency demonstrated by consumers and midwives within their practice settings. This focus on the abnormal and the perceived risks attached to childbearing has received attention from social scientists in numerous studies on the power of the medical profession from differing sociological perspectives (Arms,

1975; Corea, 1977; Rich, 1977; Taylor, 1979; Oakley,1981; O'Brien, 1981; Mendelsohn, 1981; Katz Rothman, 1982; Willis, 1983; Turner, 1987; Sullivan and Weitz, 1988; Donnison, 1988; Kitzinger, 1989; Garcia, Kilpatrick, and Richards, 1990;) and others. The relevance of these studies to the findings of this present study suggest that little has changed in the underlying philosophies, assumptions and values determining the directions taken and planned for future maternity care, despite the increasing crescendo of the consumer's voice in harmony with the findings of the various birthing reports, both within Australia and internationally.

8.4.4 A wide range as a profession in the perceived adequacy of current midwifery knowledge and skills

There was a significant difference in the perceptions of midwives who had practised in the past five years (EP5 group), and those who had not (NEP5 group), in their assessment of their knowledge and skills to practise according to the WHO definition (chi-square Pearson = 496.42, df 18, significance .0000). Of the EP5 group (n=882) there were 219 (24.9%) who considered their skills adequate to practise in all areas of midwifery. In comparison the NEP5 group indicated 66 (7.7%) adequate to practise in all areas. In addition, a comparison within the EP5 group between members and non-members of the ACMI demonstrated a significant difference (p=.0000) in the perception of skill and knowledge adequacy. There were 35.1% (77) practising ACMI members who considered their knowledge and skills adequate to practise in all areas compared with 21.9% (141) of the practising midwives who were not members of the college.

These findings demonstrate the effect of fragmented practice on the Australian midwives' ability to practise according to the sphere of practice as stated in the WHO Definition of a Midwife. There were 46.5% (409) of the EP5 group (n=882) who had not conducted a delivery in the past twelve months (p.97). Numerous procedures were rated as not practised in the past five years (Table 12 pp. 81-82; Table 23 pp. 93-100; and Table 34 pp. 110-121). This was particularly evident in the provision of antenatal care. The average frequency ratings for procedures not performed in the past five years were: 29.86% for antenatal tasks; 17.6% for intrapartum tasks; and 12.6% for postnatal. The greater percentage of midwives (58.9%) had not performed domiciliary postnatal care, with 77.8% not involved in the care of the infant after the first 10 days.

8.5 Recommendations for midwifery practice

The following recommendations are based on acknowledgment of the discrepancies between the actual role of the Australian midwife and the stated role according to the *Standards for the Practice of Midwifery* (ACMI, 1989). Factors midwives perceived as facilitators, or barriers, affecting their ability to practise to their full potential, in accordance with the International Confederation of Midwives Definition of a Midwife, have been analysed. The conceptual paradigm (Schema 1 p.198) illustrates the relationships between these factors (Chapter 7). The *core category* established through the interview data from midwives was defined as *opportunities to practise throughout all stages of childbirth.* The *core process* affecting the availability of these opportunities was *optimisation of opportunities to practise throughout all stages of childbirth.* The *core consequence* of *optimisation of opportunities to practise throughout all stages of childbirth* was *recognition of holistic midwifery practice*, where midwives were able to practise to the full extent of the role of the midwife, and to meet the *Standards for the Practice of Midwifery* (ACMI, 1989), based on the WHO definition.

The inverse was strongly demonstrated throughout the data. The dimensions of the *core category* extended from opportunities to practise being fully available to opportunities being totally limited. The dimensions of the *core process* of optimisation of opportunities to practise also extended from full optimisation to no evidence of optimising behaviours. The range in the *core consequence* extended from recognition of the holistic role of the midwife (able to practise to the full extent of the WHO *Definition of a Midwife*) to recognition of the fragmented role of the obstetric nurse (Schema 1 p. 198).

The discrepancies between the stated sphere of practice and the actual demonstrated practice were the consequences of limiting interactions between health professionals and health service providers within their diverse practice settings. Schema 2 (p. 200) illustrates the complexity of conditions contributing towards limiting interactions occurring within, and influenced by practice settings. Schema One (p.198) portrays the consequences of limitation of opportunities to practise throughout all stages of childbirth. Fragmentation was the core consequence occurring as midwives' opportunities to practise holistic midwifery care were limited within different settings and through dimensions of limiting interactions. Where midwives had accepted limitation of their practice opportunities within antenatal, intrapartum and postnatal care

inclusively, they provided fragmented midwifery within specific areas. This fragmentation of midwifery knowledge and skills often resulted in midwives working as specialist obstetric nurses, subordinate to medical practitioners in the provision of maternity services. The consequences for midwives providing this fragmented practice was that they were dependent practitioners unable to practise to the full extent of the role of the midwife as specified in the *Standards for the Practice of Midwifery,*(ACMI, 1989). The consequences of integrated action/interaction processes are illustrated in Schema 3 (p.266). They form the basis of recommendations aimed at addressing the issues identified throughout this study as inhibiting Australian midwives from providing consumer focused, cost effective and efficient midwifery care, within options for care in childbirth.

Childbearing women and their families are the pivotal force of all maternity services. Recognition of their choice of model of care is paramount to the optimisation of opportunities to practise throughout all stages of childbirth. Consumer studies and reports at international and national levels have established women's preference for continuity of care throughout pregnancy and childbirth (Flint & Poulengeris, 1987; Davies & Evans, 1991; Thomson, 1991; NSWDH, 1989; HDV, 1990; Bartlett & Pennebaker, 1991; HDWA, 1991; Changing Childbirth, 1993; Campbell & Macfarlane, 1994; Rowley, 1995; Select Committee on Intervention in Childbirth, 1995; NHMRC, 1996). These evaluative studies and reports recognise the role of the midwife in providing consumer focused care within all models of service delivery.

8.5.1 Recommendations based on optimising opportunities for holistic practice

Recommendations for midwifery practice arising from this study are focused on the core category, *opportunities to practice throughout all stages of childbirth.* The process of *optimising holistic practice opportunities* underpins implementation of these recommendations. The demonstrated consequences of midwives' actions and interactions throughout the four stages of optimising holistic practice opportunities are the basis on which these recommendations have been made.

8.5.2 Stage one: revealing the image

Opportunities to be optimised by midwives follow on from the recognition of choice of model of care for the childbearing women and their families. Based on the findings of

this study it is recommended that:

1. Information regarding models of maternity care be made available throughout the community. This should involve a concerted coordinated publicity awareness program supported by the Health Departments of each state. The Options for Childbirth (NHMRC 1996) should be used as the basis for the development of consumer information on choices of models of care.

2. The role of midwives within different models of maternity care and practice settings should be defined initially through the Australian College of Midwives, based on the models of care recommended by the Joint Birth Consultative Committee (JBCC 1992).

The sequel to the defining of the midwife's role within models of maternity service provision is the identification and development of extended spheres of practice within models of maternity service provision. Reference has been made by midwives throughout the study to the different specialised knowledge and skills, attitudes and values, required by the midwife to practise competently within different models of care. Competencies have been developed through the Midwifery Strategic Planning Committee of the ACMI currently in the third version to be formally tested in practice in 1996 (ACMI, 1995). These competencies have been formulated through submissions from midwives, circulation of draft versions of competencies, research (Glover, 1991), comments received from various Nurses Boards and the Australian Nursing Council Incorporated, and validation workshops. It is expected that the competencies will be used *as a basis for the assessment of midwife performance or appraisal.* These ACMI competencies have been derived from the *Standards for the Practice of Midwifery* (ACMI, 1989). It can be extrapolated therefore that attainment of the competencies would equate with midwives able to demonstrate the knowledge, skills, attitudes and values, to practise to the full extent of the WHO (1976) *Definition of a Midwife*, also referred to as the International Confederation of Midwives' Definition of a Midwife (adopted 1972, amended 1990).

The recommendations based on the findings of this study in relation to the development of extended roles within midwifery practice are that:

3. Tasks identified by midwives as being *most usually performed following policies and procedures, or practised independently,* during the provision of antenatal (Table 12 pp.81-83), intrapartum (Table 23 pp.93-100), and postpartum care (Table 34 pp. 110-121), should be recognised as forming the core components of midwifery practice. Midwives should accept responsibility and accountability for their actions during the provision of this midwifery care.

4. Tasks identified by midwives as being *most usually performed following direct medical orders, or assisting a medical practitioner* (Table 52 p. 153) should also be considered as required midwifery skills within specific models of care. Midwives practising within models of service delivery where they are required to assist in the provision of obstetrical care should be deemed competent by the employing organisation to perform these tasks. Midwives must maintain competencies in executing emergency measures within all models of service delivery.

8.5.3 Stage two - influencing decision making

The findings of this study support Barclay's (1985; 1995) descriptions of the subordinated role of the midwife within Australian maternity services. The dominance of the medical profession through the process of subordination described by Willis (1983) is also demonstrated throughout the findings of this present study. Failure by midwives to optimise opportunities to influence decision making was explained within the contextual categories affecting midwives' ability to practise to the full potential of their acknowledged role. It was demonstrated in this study that where midwives displayed optimising actions and interactions within their practice settings and their interrelationships with consumers and health professionals, they revealed the role of the midwife within the various models of care. The covert role identified by Barclay (1985) as depicting the public perception of the midwife as a dependent practitioner, was overtly revealed where midwives displayed the characteristics and qualities of an independent practitioner involved in autonomous decision making.

The recommendations for stage two of optimising holistic practice opportunities reflect the interdependent relationships required amongst maternity health care providers and consumers of maternity services. It is recommended that midwives influence decision making by:

5. Being actively involved, in collaboration with other maternity care providers, in formulating policies and procedures that control their practice.

6. Maternity health service organisations should accept responsibility for collaborating with maternity care providers, to determine the models of service provided by their organisations and the competencies required by health professionals within each model of care.

In addition:

7. The counselling role of the midwife during the preconceptual and antenatal periods should be developed to meet the specific needs of women and their families within different settings and circumstances.

8.5.4 Stage three - changing the paradigm

The consequences of the domination of the medical model of childbirth over a more social or natural model were fragmentation of the midwives' practice and lack of continuity of care for the childbearing women and their families. This finding is congruent with research discussed in Chapter Two (Balaskas, 1984; Odent, 1984; Flint, 1986; Enkin, Keirse, Renfrew and Neilson, 1995:16). The successful outcomes in terms of maternal and infant morbidity and mortality in countries recognising midwifery models of care reflecting a more social or natural approach have been acknowledged (World Health Organisation, 1985; Report of the Expert Maternity Group-Department of Health, 1993; National Health and Medical Research Council, 1995).

Recommendations based on optimising actions and interactions demonstrated by midwives in this present study as contributing towards changing the paradigm for maternity care within Australia include models of midwifery care being introduced to

provide more continuity of care, and carer, for the childbearing women and their families. It is recommended that:

8. Within all models of maternity service delivery midwives collaborate with other care providers to enhance continuity throughout antenatal, intrapartum and postnatal care to childbearing women and their families. The diversity of models of service provision should not be a deterrent to continuity of care. Midwives' opportunities to provide continuity of care throughout antenatal, intrapartum and postnatal care inclusively should be optimised within all models of service delivery.

9. Continuity of care should be instigated during the antenatal period. The concept of women knowing a midwife, or team of midwives, throughout pregnancy and childbirth could be adapted through consultation between women and their care providers within all models of service delivery.

The woman's choice of caregiver should be respected and collegiate relationships between care providers developed and maintained. Consequently:

10. The practice of interruption of the conduct of normal labour and delivery when the birth of the baby is imminent should be questioned on moral grounds by all intrapartum care providers. Where women have chosen a care giver to conduct the birth that care giver should be available in adequate time to avoid subjecting the women and their families to unnecessary haste and anxiety.

11. Where early discharge from hospital occurs midwives should continue with domiciliary care as required postnatally. Termination of care should be determined in consultation with the women. Referrals for ongoing midwifery care should be made to community or child health nurses.

8.5.5 Stage four - expanding the profession

The challenge to maintain adequate midwifery skills to provide competent safe care within all models of service delivery was demonstrated throughout the findings of the

study. Limited opportunities to practise throughout all stages of pregnancy and childbirth were seen to result in fragmentation of practice and skills. Midwives indicated a wide range in their perceptions of the adequacy of their knowledge and skills to optimise opportunities to practise throughout all stages of childbirth. This reinforced the importance of continuity of carer on the confidence of midwives in their practice. The following recommendations are made for the development of improved midwifery knowledge and skills. It is recommended that:

12. Midwives rotate within areas of practice to optimise opportunities to practise within all areas of midwifery care provided within the women's choice of models of care. Also that:

13. Improved midwifery knowledge and skills be developed through peer review and clinical case studies within, and throughout, all models of maternity service provision.

14. Following testing and validation of the ACMI Competencies (1995) they should be accepted with the accompanying Philosophical Statement (ACMI, 1995), as the foundation for midwifery curricula. As stated by the Midwifery Competency Strategic Planning Committee (ACMI, 1995) adaptations can be made to suit the level and context of midwifery practice. In addition it is recommended that:

15. The ACMI coordinate the development of educational packages for specialised knowledge and skills required for extended roles for midwives within specialised models of maternity service provision. These educational packages would be in addition to post graduate tertiary studies available to midwives.

The findings from this study demonstrated that where the four stages of optimising actions and interactions by midwives throughout practice settings were in evidence midwives practised to the full extent of their holistic role, demonstrating increased self esteem and confidence. They were empowered to develop collegiate interrelationships with other maternity care providers, and to work together towards the empowerment of

childbearing women. This empowerment of women was intrinsic to their ability to make informed choices regarding the model of care that provided them with the best outcome for the women's pregnancy, birthing and parenting experiences. It is therefore recommended that:

16. Within each maternity service practice setting opportunities to develop collegiate relationships between all maternity care providers be actively encouraged through agreed philosophies of care, developed with input from providers and consumers within the communities utilising specific practice settings.

The subordination of the midwifery profession by the nursing profession, and its subsumption and domination by the medical profession were issues identified by midwives as being incompatible with collegiate professional relationships and optimising interactions within practice settings. Recognition of the role of the midwife was dependent upon holistic midwifery practice often limited by interactions between maternity care providers. Recommendations have been made through maternity services reports that address these issues. Representation on Nurses Boards and the Australian Nursing Council have been recommended by the NHMRC (1996) and the Select Committee on Intervention in Childbirth (1995). The ACMI has initiated negotiations with the Australian Nursing Council to set up a Midwifery Registration Board with a ACMI appointed representative to oversight matters related to midwifery registration.

The findings of this present study indicate a diversity of opinion amongst practising midwives regarding their *dual professionalism.* It is therefore recommended that:

17. Consultation in regard to professional issues affecting nurses and midwives should include midwives not currently members of the ACMI. Communication should be established between the ACMI and the larger component of nurse/midwives practising throughout Australia. This could be achieved through the Australian Nursing Federation with its considerably higher midwifery membership of 44% from the same randomly selected sample of midwives.

This communication with non ACMI members is essential to the future development and growth of the College. Midwives in practice settings throughout NSW, Victoria and Western Australia spoke of the invisibility of the College, and its perceived irrelevance to their practice. This lack of recognition of the ACMI by practising midwives is an issue the College must address if it is to represent the midwifery profession, and achieve the commendable *Action Plan for the Triennium 1994-1997* (ACMI, 1995).

8.6 Conclusions and implications for further research

The findings of this study fully support the ACMI's stated aims, strategies, goals, objectives and proposed actions to achieve specific outcomes that aim:

> *To strengthen the profession of midwifery.*
> *To develop the role of the midwife as an autonomous professional practitioner.*
> *To improve the standard of care provided to mothers, women, babies and their families.*
> *To advance the provision of midwifery and women's health services in collaboration with other health professionals and consumers.*
> *To advance within the Asia Pacific Region the potential of the midwife, and the value of midwifery in achieving the reduction in the rates of maternal and neonatal mortality and morbidity.*

The credibility of these aims needs to be assessed by practising midwives and their support solicited in implementing the ACMI's Action Plan. Consultation regarding the setting up of effective communication is required between the ACMI, the Australian Nursing Council, the Australian Nurses Federation, the states' Nurses Boards and Nursing Colleges, and the states' Health Departments. This should be the first initiative towards a marketing strategy focused on recognition of the midwife's role in providing improved maternity services for childbearing women and their families.

With support from midwives practising throughout Australia the ACMI's professional and political strength will be enhanced in its continuing efforts to remove the limitations imposed on midwives' opportunities to provide holistic care, and to achieve recognition as interdependent practitioners within the maternity services, providing midwifery care that meets the expectations of childbearing women and their

families within their chosen models of care.

In conclusion, this project has identified what midwives do in the diverse practice settings throughout Australia. It has evaluated midwives' actual practice against the *Standards for Midwifery Practice* (ACMI, 1989), and it has identified factors detracting from the efficient, effective utilisation of midwives within the maternity care team. Recommendations made have been based on the consequences of optimising interactions demonstrated within various settings and models of service delivery throughout Australia. The four stages of optimisation of opportunities to practise throughout all stages of childbirth have been demonstrated to be components of a cyclical process where each stage is dependent on the other.

The study has provided a broad based analysis of the Australian midwives' practice domain. Further research into the optimising of opportunities for holistic midwifery practice will contribute towards developing effective strategies within each of the identified stages: revealing the image; influencing decision making; changing the paradigm; and expanding the profession. The development of a holistic role within all models of maternity services is dependent on research based practice. Outcomes for consumers need to be continually evaluated within the various models and across the diverse practice settings.

While this study has focused on the practice domain of Australian midwives, the interdependency of education, research and management with practice has been an underlying assumption throughout this research. Ongoing research in all areas of midwifery is imperative to the growth of the profession. An oration, *Unity in Diversity,* presented at the Inaugural Investiture of Fellows of the Australian College of Midwives by Peters (1995) included the question:

> *Is it time to redefine the role of the midwife in this country to examine just what diversity can be achieved while remaining true to that which unified us? I believe so* (Peters, 1996).

Midwives practise within the models identified by the Joint Birth Consultative Committee as: midwifery care; general practitioner obstetric care; specialist obstetric care; and shared care. The elements of the traditional role of the midwife remain essential within each model. These elements have been identified in this present

analysis of Australian midwifery practice. As the role of the midwife within each of these models continues to be influenced by changing consumer expectations, increasing technology, economic restraints, and professional expansion and integration, midwives within their practice settings are ideally placed to participate in evaluative research. The role of the midwife in providing effective, efficient and equitable maternity care to childbearing women and their families can only be demonstrated through interdependent practice within models of care focusing on the best possible outcomes for the childbearing women and their families.

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APPENDIX 1

Advisory Panel of Midwives

Appendix 1

ADVISORY PANEL OF MIDWIVES

Robyn Cottam RN, RM, B.App.Sc.	Clinical Nurse/Educator
Kath Croft RN, RM, CHN, B.App.Sc.	Policy and Planning, HDWA
Hillary Cross RN, RM, B.App.Sc.	Neonatal Intensive Care/Educator
Marilyn Dobbyn RN, RM, B.App.Sc.	Lecturer - Curtin University
Vivian Gee RN, RM, CHN, B.App.Sc.	Health Statistitian
Sue Lasky RN, RM, MHN	Clinical Nurse Specialist
Christine Lock RN, RM, B.App.Sc., M.N.	Clinical Nurse Specialist
Catherine McKinley RN, RM, B.App.Sc.	Clinical Nurse Specialist
Mary Murphy RN, RM, B.App.Sc.	Midwife in Private Practice
Dorothy Samson RN, RM, B.App.Sc., Post Grad. Dip.	Administration
Robin Symonds RN, RM, B.App. Sc.	Staff Development
Carol Thoroughgood RN, RM, B.App.Sc., M.Ed.,	Lecturer - Curtin University
Jennifer Wrightson RN, RM, B.App.Sc.	Clinical Nurse Specialist

APPENDIX 2

Questionnaire - A Survey for Midwives

AUSTRALIAN MIDWIVES'

PRACTICE DOMAIN

A SURVEY FOR MIDWIVES

Conducted by

Miriam Cullen R.N., R.M.,
Post Grad. Dip. (Nursing) M.H.A.,
Ph.D candidate
Curtin University of Technology

Please tear off this Legend at the perforations, and use when answering the questions which start on pages 15, 22 & 31. Please only mark the box which indicates the level at which you MOST USUALLY PERFORM these activities.

A *Assisted with procedure performed by Medical Practitioner*

B *Self performed under direct supervision of Medical Practitioner present at the time*

C *Self performed under indirect supervision of a Medical Practitioner following his / her verbal or written orders*

D *Self performed following organisational policies and procedures*

E *Practiced independently, i.e. autonomous decision making*

F *Not practiced during the past five years*

A SURVEY FOR MIDWIVES

Dear Midwife,

This questionnaire has been sent to you as part of a study to look at what midwives do in their many different roles throughout Australia.

The purpose of the study is to collect factual information on the contribution midwives make to the care of child bearing women and their families in the diverse settings and circumstances found in this country.

Your responses to this questionnaire will be used to compare midwives present practice with the W H O International definition of a midwife and the A C M I standards for the practice of midwifery. Factors that are seen by midwives to either help or hinder their ability to provide maternity and child care at the stated level and standard will be followed up in interviews with practising midwives.

The findings of both the questionnaire and the interviews will contribute towards an evaluation of midwifery practice, and the issues affecting midwives. This knowledge can then be used to plan and prepare for the full utilisation of the midwives' knowledge and skills in the provision of maternity and child care that reflects the expressed needs and values of women and their families throughout Australia.

Some of you will not be currently practising midwifery. It is still important for you to respond to the questionnaire. Your experiences are also valuable in understanding the factors affecting midwives and their practice.

Midwives who have taken part in trialing the questionnaire have been enthusiastic. Most have said how surprised and pleased they have been when pausing to think what it is they "know, feel and do", which has become part of their day to day work.
I hope that you will feel the same sense of satisfaction as you take time to consider your practice and experiences as a midwife.

A coding system will be used in co-operation with the Nurses Boards of each State to ensure that confidentiality is respected.

Your response whatever it may be, is of importance to me.

Please answer the questionnaire and return it as soon as possible using the reply paid envelope. Thank you.

If you **cannot,** or if you **don't want to** answer the questionnaire, **Mark the appropriate box or boxes indicating your reason(s).**

☐ Too busy ☐ Not interested ☐ Couldn't understand it
☐ Don't wish to be involved ☐ Don't care about midwifery now
☐ Other (please state) .....

Please return as soon as possible using the reply paid envelope.

Thank you for your time and co-operation.

Yours sincerely,

Miriam Cullen.

This study is stage two of a Ph.D thesis titled 'Australian Midwives Practice Domain'. Stage two has been jointly funded by the Nurses Memorial Bush Bequest Grant; the Olive Anstey Nursing Fund; and the Nurses Board of Western Australia.

For the purpose of this questionnaire the following definitions apply:

Definitions

International definition of a midwife :-

"A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She/he must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the new born and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service", (World Health Organisation 1976).

Midwifery :- the management and care of

(a) women during pregnancy, childbirth and the puerperium.

(b) the newborn during the puerperium.

Practicing midwife - a midwife currently registered to practice with one of the Nursing/Midwifery registering authorities in Australia.

Antenatal or Antepartum - the period of time between conception and the commencement of labour.

Intrapartum - the period of time from the commencement of labour to the completion of the third stage of labour.

Postnatal or Postpartum - the period of time from completion of the third stage of labour to six weeks following childbirth.

Puerperium - the six weeks period following childbirth.

Levels of care - as defined by The Australian College of Paediatrics. (Appendix 1 Australian College of Midwives Incorporated 1989).

Standards for the practice of midwifery - as defined by the Australian College of Midwives Incorporated (1989).

SECTION ONE

A few questions about yourself as an introduction.
(Please mark the appropriate box or boxes).

Leave this column blank on all pages.

1-4

1 a. Year of birth 19☐☐ — 5

1 b. Female ☐ Male ☐ — 6

1 c. Your post code ☐☐☐☐ — 7

2. Country of birth Australia ☐ U.K. or Ireland ☐
N.Z. ☐ Europe ☐ Asia ☐ U.S.A. ☐ Other ☐ — 8

3. Is English your first Language Yes ☐ No ☐ — 9

4. In which country did you obtain your initial qualification as a midwife Australia ☐ U.K. or Ireland ☐
N.Z. ☐ Europe ☐ U.S.A. ☐ Asia ☐
Other please state ☐ ..... — 10

5. In which year did you obtain your initial midwifery qualification 19☐☐ — 11

6. In which year were you first registered to practice midwifery in Australia 19☐☐ — 12

7. Have you undertaken a refresher course to re-register at any time Yes ☐ No ☐ If Yes - When 19☐☐ — 13 14

8. Please indicate which, if any, courses you have successfully completed beside your midwifery -:

- ☐ General Nursing — 15
- ☐ Child health — 16
- ☐ Neonatal intensive care nursing — 17
- ☐ Bachelors Degree (Health Science) — 18
- ☐ Bachelors Degree (Other) — 19
- ☐ Post Graduate Diploma — 20
- ☐ Masters Degree — 21
- ☐ Ph.D. — 22
- ☐ Certificate or Diploma in Management — 23
- ☐ Certificate or Diploma in Education — 24
- ☐ Certificate or Diploma in clinical nursing specialties. Please state ..... — 25
  .....
- ☐ ..... — 26
- ☐ Certificate or Diploma in non nursing specialty please state ..... — 27
  .....

9. To maintain your professional midwifery knowledge at current levels have you participated in any of the following activities during the past twelve months.
(Please mark the appropriate box or boxes).

- ☐ regular reading of current professional midwifery/obstetric journals — 28
- ☐ studying current midwifery/obstetric books and or texts — 29
- ☐ attending midwives professional meetings — 30
- ☐ attending clinical lectures, seminars or workshops — 31
- ☐ clinical review — 32
- ☐ diverse practice opportunities — 33
- ☐ others (please state) ..... — 34
  .....
  .....
  .....

(Please mark the appropriate box).

10. Have you been employed as a midwife at any time during the past five years. Yes ☐ No ☐ 35

If you marked No - which of the following factors was the reason for your non employment as a midwife (Please mark appropriate box or boxes).

- ☐ No midwifery position available 36
- ☐ family or personal commitments 37
- ☐ lack of career opportunity 38
- ☐ disliked midwifery 39
- ☐ preferred other nursing options 40
- ☐ lacked confidence in my midwifery practice 41
- ☐ retirement 42
- ☐ other - please state..... 43
- ☐ another - please state 44

11. Have you been employed in any other capacity during the past five years where your midwifery knowledge and skills were utilised? If so please state type of work. 45
..... 46

12. Since completing your midwifery training/education, for how many years have you practiced as a midwife.
Please state ☐☐ years ☐☐ months. 47

13. As a registered midwife, which of the following categories would best describe <u>The Majority</u> of your midwifery experience? **(Please mark one box only).**

- ☐ never practiced
- ☐ clinical practice (includes patient education)
- ☐ midwifery education / staff development 48
- ☐ nursing administration / management
- ☐ other please state.....

14. During your employment as a midwife how would you rate the utilisation of your midwifery knowledge and skills? **(Please circle the most applicable number).**

a. Knowledge

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	49

b. Skills

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	50

15. How would you rate your satisfaction with the division of responsibility for perinatal care as it affected your role within the health care team? **(Please circle the most applicable number).**

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	51

16. Have you read the Australian College of Midwives incorporated " Standards for the Practice of Midwifery" (1989) **(Please circle the correct response).**

YES NO 52

17. Do you consider the International Confederation of Midwives definition of a midwife (WHO 1976) and the sphere of practice to be a good description of the role of the Australian midwife. **(Please choose your level of acceptance from the options below) :-**

- ☐ Yes - as an ideal to be aimed for but not currently practised fully by Australian midwives 53
- ☐ Yes - as currently practised by Australian midwives
- ☐ No

Any comments on Question 17 ?

.....

.....

.....

18. To what extent did / does your midwifery practice reflect the sphere of practice described by the W.H.O. international definition of a midwife?

1	2	3	4	5
no similarity	some similarity	similar	well reflected	fully reflected

54

19. How adequate do you consider your level of midwifery knowledge to be in order to fulfil the requirements of the international definition of a midwife? **(Please circle the most appropriate number).**

1	2	3	4	5
inadequate	inadequate in some areas	adequate in most areas	adequate in all areas	more than adequate

55

20. How adequate do you consider your midwifery skills competency level to be, to fulfil the requirements of the international definition of a midwife? **(Please circle the most appropriate number).**

1	2	3	4	5
inadequate	inadequate in some areas	adequate in most areas	adequate in all areas	more than adequate

56

21. Using a 1 - 4 scale, how would you rate the following factors as requirements to help midwives meet the W H O International definition of a midwife? **(Please circle the most appropriate number).**

a. Opportunity to provide care throughout all stages of pregnancy and childbirth.

1	2	3	4
not important	fairly important	important	essential

57

b. Changes to legislation to remove some of the restrictions affecting the midwives' practice domain

1	2	3	4
not important	fairly important	important	essential

58

c. Changes to organisational policies and procedures

1	2	3	4
not important	fairly important	important	essential

59

d. Increased opportunities for continuing education.

1	2	3	4
not important	fairly important	important	essential

60

e. Greater recognition of midwifery knowledge and skill by the community.

1	2	3	4
not important	fairly important	important	essential

61

f. Greater recognition of midwifery knowledge and skill by the medical profession.

1	2	3	4
not important	fairly important	important	essential

62

g. Greater recognition of midwifery knowledge and skill by the nursing profession.

1	2	3	4
not important	fairly important	important	essential

63

Decreased medical intervention in normal childbirth

1	2	3	4	
not important	fairly important	important	essential	64

Any comments.....
.....
.....
.....

22. Considering the factors in question 21 - What level of satisfaction do you feel in regard to these as they apply to your own experience and practice.
(Please circle the most applicable number).

a. Your opportunities to provide care throughout all stages of pregnancy and childbirth.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	65

b. The effect of legislation on your potential to practice.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	66

c. The effect of organisational policies and procedures on your potential to practice.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	67

d. Your present level of knowledge and skills.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	68

e. Recognition of your knowledge and skills by the community.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	69

f. Recognition of your knowledge and skills by the medical profession.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	70

g. Recognition of your knowledge and skills by the nursing profession (including midwives).

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	71

h. The level of medical intervention in normal childbirth.

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	72

23. Are you a member of any of the following :-
(Please mark applicable box or boxes).

- ☐ Australian College of Midwives Inc. 73
- ☐ Royal College of Nursing Australia 74
- ☐ New South Wales College of Nursing 75
- ☐ Australian Nursing Federation 76

24. Have you been a consumer of obstetric and neonatal services within Australia during the past twelve months, as :- **(Please mark one box only).** 77

a. a childbearing woman ☐
b. an involved family / friend ☐
c. not involved at all ☐

9/

d. As a consumer of obstetric services in Australia please rate your satisfaction with the following on a 1 to 3 basis. 1 = Satisfied 2 = Needs Improving 3 = Not Involved

1.	Information given by midwives	1	2	3	78
2.	Support given by midwives	1	2	3	79
3.	Care given by midwives	1	2	3	80
4.	Competence of the midwives	1	2	3	1
5.	Interpersonal skills of midwives	1	2	3	2
6.	Availability of midwives	1	2	3	3

If you have any further comments you would like to make regarding this section, please do so in the blank space following.

If you HAVE been employed as a midwife at any time during the past five years, PLEASE CONTINUE on with SECTION TWO on page 10 after making your comments.

If you have NOT been employed as a midwife during the past five years, you have now completed your section of the questionnaire. After making your comments, please return the questionnaire in the reply paid envelope provided for your convenience as soon as possible.

Your co-operation in providing this information is appreciated, thank you.

SECTION TWO

To be completed by all midwives who have been employed as a midwife at any time during the past five years. This includes clinical, education, management or research positions.

1. In which of the following countries and/or Australian states have you practised for a period not less than three months ?
(please mark appropriate box or boxes).

☐ U.K. or Ireland ☐ N.Z. ☐ Europe
☐ Asia ☐ America ☐ Other

☐ A.C.T. ☐ Northern Territory ☐ N.S.W.
☐ Queensland ☐ S.A. ☐ Tasmania
☐ Victoria ☐ W.A.

2. Using the Australian College of Paediatrics definitions of levels of care, **(see Appendix 1)** what level of care do the organisations you have been employed by during the past five years provide? **(Please mark appropriate box or boxes).**

☐ Level 1 ☐ Level 2 ☐ Level 3

3. How often has your standard of practice been evaluated against professional standards through self evaluation and peer review during the past five years.
(please mark the most applicable box).

☐ annual appraisal (by self and peer(s))
☐ no official appraisal
☐ annual self evaluation (documented)
☐ official appraisal more than once in five years but not annually

4. Which of the following statements best reflect your view of performance appraisal as related to your own experience? **(Please mark the appropriate box or boxes).**

- ☐ good opportunity for feedback from peers 22
- ☐ motivating objective setting process 23
- ☐ reflective evaluation of performance 24
- ☐ time wasting 25
- ☐ controlling mechanism of hierarchy 26
- ☐ pressure to increase performance 27
- ☐ unnecessary for professionals 28

5. Have you participated in continuous quality improvement to customer services in any of the following ways **(Please mark appropriate box or boxes).**

- ☐ setting family orientated goals with input from the consumer 29
- ☐ using a problem solving approach in providing perinatal care 30
- ☐ promoting safe environmental standards 31
- ☐ reporting accidents and incidents 32
- ☐ meeting legal requirements for documentation 33
- ☐ acting as the consumers advocate 34
- ☐ participating in clinical care reviews with other health professionals 35
- ☐ evaluation of consumer outcomes 36
- ☐ providing input to policies and procedures guiding consumer focused services 37
- ☐ other - please state 38

.....

.....

.....

6. In which of the following ways have you participated in research designed to improve perinatal care? **(Please mark appropriate box or boxes).**

- ☐ data collection used for research purposes e.g. midwives notification form 39
- ☐ clinical trial conducted by midwives and/or other health professionals 40
- ☐ as principal investigator in research project 41
- ☐ publication of research findings 42
- ☐ implementation of current research findings 43

7 As a practicing midwife, which of the following professional development activities have you participated in during the past twelve months. **(Please mark the appropriate box or boxes).**

- ☐ orientation of midwives 44
- ☐ preceptoring student midwives and/or 'refresher' midwives 45
- ☐ clinical care group presentation to midwifery colleagues 46
- ☐ demonstration of advanced clinical skill(s) 47
- ☐ midwifery practice seminar presentations 48

Brief comments on this section.

SECTION THREE

Antenatal Midwifery Practice
Clinical, Management, Education or Research

1. **(Please circle the correct answer).**
Have you been involved in antenatal services during the past five years?

YES NO 49

If answer to Q1 was No go to SECTION FOUR

If answer to Q1 was Yes proceed with Q2

2. Did your antenatal care practice involve :-
(Please mark applicable box or boxes).

a.	clinical care, includes individual client teaching	☐	50
b.	antenatal / parent education for client groups	☐	51
c.	education for midwives	☐	52
d.	management of antenatal services	☐	53
e.	research	☐	54

3. Did your antenatal care include the families of the childbearing women? **(Please circle the correct answer).**

YES NO 55

4. **Please mark the appropriate box or boxes** indicating the settings in which you have provided antenatal care in the past five years:-

	Public	Private	
a. hospital inpatient care	☐	☐	56
b. hospital clinic outpatient care	☐	☐	57
c. women's health centre (or clinic)	☐	☐	58
d. family planning centre (or clinic)	☐	☐	59
e. medical practitioner's surgery	☐	☐	60
f. domiciliary setting	☐	☐	61
g. other (please state).....	☐	☐	62

5. On a scale of one to five, where would you rate your knowledge on the following aspects of antenatal care? **Please circle.**

		Little Knowledge	Some Understanding	Good Understanding	V/Good Understand.	In Depth Knowledge	
a.	physiological factors affecting pregnancy outcomes	1	2	3	4	5	63
b.	anatomical factors affecting pregnancy outcomes	1	2	3	4	5	64
c.	biological factors affecting pregnancy outcomes	1	2	3	4	5	65
d.	environmental factors affecting pregnancy outcomes	1	2	3	4	5	66
e.	psycho-social factors affecting pregnancy	1	2	3	4	5	67

6. Using the Legend below, please indicate at what level of autonomy you have **MOST USUALLY** performed the following activities during the past five years.
If you have NOT provided direct client antenatal care or education please go to question 7 Page 17.

LEGEND **Please tear off the Legend on the back cover for your convenience with the following pages.**

A. Assisted with procedure performed by Medical Practitioner
B. Self performed under direct supervision of a Medical Practitioner - present at the time
C. Self performed under indirect supervision of a Medical Practitioner following his/her verbal or written orders
D. Self performed following authorised organisational policies and procedures
E. Practiced independently i.e. autonomous decision making
F. Not practised during the past five years

	Please mark one box only (most usually performed level).	**A**	**B**	**C**	**D**	**E**	**F**	
a.	preconceptual care counselling	☐	☐	☐	☐	☐	☐	68
b.	antenatal care counselling	☐	☐	☐	☐	☐	☐	69
c.	obtaining and documenting a medical surgical history	☐	☐	☐	☐	☐	☐	70
d.	obtaining and documenting an obstetrical history	☐	☐	☐	☐	☐	☐	71
e.	obtaining and documenting a psycho/social history	☐	☐	☐	☐	☐	☐	72
f.	conducting an initial maternal physical assessment	☐	☐	☐	☐	☐	☐	73

		A	**B**	**C**	**D**	**E**	**F**	
g.	subsequent abdominal assessment palpation and auscultation	☐	☐	☐	☐	☐	☐	74
h.	subsequent vital signs assessment	☐	☐	☐	☐	☐	☐	75
i.	ultrasound	☐	☐	☐	☐	☐	☐	76
j.	cardiotocograph (procedure)	☐	☐	☐	☐	☐	☐	76
k.	C T G (interpretation)	☐	☐	☐	☐	☐	☐	78
l.	fetal heart monitoring with pinards stethoscope or doppler	☐	☐	☐	☐	☐	☐	79
m.	ordering laboratory tests	☐	☐	☐	☐	☐	☐	80
n.	venipuncture	☐	☐	☐	☐	☐	☐	1
o.	taking vaginal/cervical swabs	☐	☐	☐	☐	☐	☐	2
p.	urinalysis	☐	☐	☐	☐	☐	☐	3
q.	development of a family orientated pregnancy care plan **(Please circle one of the numbers only, and mark the appropriate legend box).**							
	1 plan discussed with client	☐	☐	☐	☐	☐	☐	4
	2 plan written	☐	☐	☐	☐	☐	☐	5
	3 plan discussed and written	☐	☐	☐	☐	☐	☐	6

		A	B	C	D	E	F	
r.	identification of factors requiring referral to other health professionals	☐	☐	☐	☐	☐	☐	7
s.	care of high risk clients	☐	☐	☐	☐	☐	☐	8
t.	other antenatal clinical practices please state.....	☐	☐	☐	☐	☐	☐	9

7. Please circle your highest level of input in the development of the policies and procedures guiding the practice of antenatal care **(Please circle one number only).**

1 no input
2 very little input
3 indirect input i.e. formal meetings and discussion
4 direct preparation of policies and procedures
5 involved in determination of policies and procedures

10

8. With which of the following health professionals (other than midwives and nurses) did you liaise in the provision of antenatal care **(Please mark the appropriate box or boxes).**

general practitioners (medical)	☐	11
specialist obstetrician/gynaecologists	☐	12
paediatricians	☐	13
anaesthetist	☐	14
other than the above medical practitioner (please state.....	☐	15
social workers	☐	16
psychologists	☐	17
dietitian	☐	18
physiotherapists	☐	19
occupational therapists	☐	20
ministers of religion	☐	21
radiologists	☐	22
pathologists	☐	23
pharmacists	☐	24
other(s) (please state).....	☐	25

9. How would you rate the utilisation of your midwifery knowledge and skills in the provision of antenatal care? **(Please circle the most applicable number).**

a. Knowledge

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	26

b. Skills

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	27

10. How would you rate your satisfaction with the division of responsibility for antenatal care as it affects your role within the health care team? **(Please circle the most applicable number).**

1	2	3	4	5	
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied	28

Please use the following page for further comments on section three.

Please use this page for comments on section three.

SECTION FOUR

Intrapartum Midwifery Practice. Clinical, Management, Education or Research.

1. **(Please circle the correct answer).**
Have you been involved in intrapartum services during the past five years?

YES NO 29

If answer to Q1 was No go to Section FIVE

If answer to Q1 was Yes proceed with Q2

2. Did your intrapartum care practice involve :-
(Please mark applicable box or boxes).

a. clinical care ☐ 30
b. intrapartum education for the clients ☐ 31
c. education for midwives ☐ 32
d. management of intrapartum services ☐ 33
e. research ☐ 34

3. Did your intrapartum care include the families of the childbearing women?
(Please circle correct answer).

YES NO 35

4. **Please mark the appropriate box or boxes** indicating the settings in which you have provided intrapartum care in the past five years:-

	Public	Private	
a. Specialist Obstetrician hospital inpatient care	☐	☐	36
b. General Practitioner hospital inpatient care	☐	☐	37
c. Birth Centre	☐	☐	38

		Public	Private	
d.	Alternative Birthing Suite (attached to a labour ward)	☐	☐	39
e.	domiciliary setting	☐	☐	40
f.	other (please state)	☐	☐	41

5. **Please circle** - On a scale 1 to 5, how would you rate your knowledge on the following aspects of intrapartum care:-

		Little Knowledge	Some Understanding	Good Understanding	V/Good Understand.	In Depth Knowledge	
a.	physiological factors affecting maternal and newborn outcomes	1	2	3	4	5	42
b.	anatomical factors affecting maternal and newborn outcomes	1	2	3	4	5	43
c.	biological factors affecting maternal and newborn outcomes	1	2	3	4	5	44
d.	environmental factors affecting maternal and newborn outcomes	1	2	3	4	5	45
e.	psycho-social factors affecting maternal and newborn outcomes	1	2	3	4	5	46

If you have NOT provided direct intrapartum client care please go now to question 7 on page 27.

6. Using the Legend, please indicate at what level of autonomy you have **MOST USUALLY** performed the following activities during the past five years.

LEGEND

A. ***Assisted with procedure performed by Medical Practitioner***

B. ***Self performed under direct supervision of a Medical Practitioner present at the time***

C. ***Self performed under indirect supervision of a Medical Practitioner following his/her verbal or written orders***

D. ***Self performed following organisational policies and procedures***

E. ***Practiced independently, i.e. autonomous decision making***

F. ***Not practised during the past five years***

1st STAGE LABOUR

a. Obtaining client assessment data base:- (Please mark one box only).	**A**	**B**	**C**	**D**	**E**	**F**	
1. client history	☐	☐	☐	☐	☐	☐	47
2. family focused psychosocial assessment	☐	☐	☐	☐	☐	☐	48
3. physical assessment	☐	☐	☐	☐	☐	☐	49

b. Initial and continuing assessment of labouring status:-							
1. abdominal palpation to assess presentation and descent	☐	☐	☐	☐	☐	☐	50
2. monitoring frequency duration and severity of contractions	☐	☐	☐	☐	☐	☐	51
3. pain assessment	☐	☐	☐	☐	☐	☐	52
4. assessment of vaginal discharge	☐	☐	☐	☐	☐	☐	53
5. assessment of cervix by vaginal examination	☐	☐	☐	☐	☐	☐	54

	A	B	C	D	E	F	
6. assessment of membranes	☐	☐	☐	☐	☐	☐	55
7. assessment of fetal position	☐	☐	☐	☐	☐	☐	56
8. station of fetus in relation to ischial spines	☐	☐	☐	☐	☐	☐	57
9. emotional status of client	☐	☐	☐	☐	☐	☐	58
10. maternal vital signs	☐	☐	☐	☐	☐	☐	59

c. Initial and continuing assessment of fetal well being:-

1. observation and assessment of fetal activity	☐	☐	☐	☐	☐	☐	60
2. identification of meconium in liquor	☐	☐	☐	☐	☐	☐	61
3. fetal heart monitoring with pinards stethoscope or doppler	☐	☐	☐	☐	☐	☐	62
4. electronic fetal heart monitoring (external)	☐	☐	☐	☐	☐	☐	63
5. electronic fetal heart monitoring (fetal scalp electrodes)	☐	☐	☐	☐	☐	☐	64
6. reading and interpretation of cardiotocograph	☐	☐	☐	☐	☐	☐	65
7. obtaining and testing fetal scalp sample for pH testing	☐	☐	☐	☐	☐	☐	66

d. Provision of care throughout 1st stage labour:-

1. provision of information about physiologic changes in labour	☐	☐	☐	☐	☐	☐	67
2. orientation to environment, staff and procedures	☐	☐	☐	☐	☐	☐	68
3. provision of comfort measures	☐	☐	☐	☐	☐	☐	69
4. promotion of privacy & respect	☐	☐	☐	☐	☐	☐	70

	A	B	C	D	E	F	
5. demonstration of breathing and relaxation methods	☐	☐	☐	☐	☐	☐	71
6. identification of hygiene, safety, social interaction/support, knowledge, nutritional, oxygenation, elimination needs	☐	☐	☐	☐	☐	☐	72
7. development of client/family orientated birthing care plan	☐	☐	☐	☐	☐	☐	73

e. Induction /augmentation of labour:-

1. assessment of cervix for induction	☐	☐	☐	☐	☐	☐	74
2. artificial rupture of membranes	☐	☐	☐	☐	☐	☐	75
3. insertion of I.V. cannula	☐	☐	☐	☐	☐	☐	76
4. administration of oxytocin by infusion	☐	☐	☐	☐	☐	☐	77
5. identification of complications	☐	☐	☐	☐	☐	☐	78
6. referral to medical practitioner	☐	☐	☐	☐	☐	☐	79
7. implementation of emergency procedures	☐	☐	☐	☐	☐	☐	80

f. Pain control:-

1. administration of anaesthetic/analgesic drugs via :-							
epidural route	☐	☐	☐	☐	☐	☐	1
inhalation	☐	☐	☐	☐	☐	☐	2
oral	☐	☐	☐	☐	☐	☐	3
intramuscular	☐	☐	☐	☐	☐	☐	4
subcutaneous	☐	☐	☐	☐	☐	☐	5
intravenous	☐	☐	☐	☐	☐	☐	6
2. acupuncture	☐	☐	☐	☐	☐	☐	7
hot bath	☐	☐	☐	☐	☐	☐	8
3. other methods of pain relief (please state)	☐	☐	☐	☐	☐	☐	9

	A	B	C	D	E	F	
g. Assessment of progress in labour:-							
1. assessment of descent of presenting part	☐	☐	☐	☐	☐	☐	10
2. assessment of effacement and dilatation of cervix	☐	☐	☐	☐	☐	☐	11
3. assessment of complications	☐	☐	☐	☐	☐	☐	12
4. recognition of transition from 1st to 2nd stage of labour	☐	☐	☐	☐	☐	☐	13
h. Preparation of client/family							
1. for 2nd stage of labour	☐	☐	☐	☐	☐	☐	14
i. Preparation of client/family for invasive procedures:-							
1. information giving and support to client/family	☐	☐	☐	☐	☐	☐	15
2. emotional preparation of client/family	☐	☐	☐	☐	☐	☐	16
3. physical preparation of client	☐	☐	☐	☐	☐	☐	17
4. preparation of environment and equipment	☐	☐	☐	☐	☐	☐	18
j. 2nd Stage Labour							
1. diagnosis of the second stage of labour	☐	☐	☐	☐	☐	☐	19
2. guiding expulsive maternal efforts	☐	☐	☐	☐	☐	☐	20
3. encouraging effective breathing and relaxation techniques	☐	☐	☐	☐	☐	☐	21
4. facilitating choice of maternal position	☐	☐	☐	☐	☐	☐	22
5. monitoring maternal well being	☐	☐	☐	☐	☐	☐	23
6. monitoring fetal well being	☐	☐	☐	☐	☐	☐	24
7. identification of failure to progress	☐	☐	☐	☐	☐	☐	25
8. conducting a spontaneous vaginal delivery	☐	☐	☐	☐	☐	☐	26
9. catheterisation	☐	☐	☐	☐	☐	☐	27
10. episiotomy	☐	☐	☐	☐	☐	☐	28
11. infiltration of the perineum with local anaesthetic agent	☐	☐	☐	☐	☐	☐	29
12. non rotational vacuum extraction	☐	☐	☐	☐	☐	☐	30
13. non rotational forceps delivery	☐	☐	☐	☐	☐	☐	31
14. rotational instrument delivery	☐	☐	☐	☐	☐	☐	32
15. assisting at Caesarean section	☐	☐	☐	☐	☐	☐	33
3rd Stage Labour							
1. administration of prophylactic oxytocics	☐	☐	☐	☐	☐	☐	34
2. cord cutting and clamping	☐	☐	☐	☐	☐	☐	35
3. controlled cord traction	☐	☐	☐	☐	☐	☐	36
4. identification of contributing causes of post partum haemorrhage	☐	☐	☐	☐	☐	☐	37
5. emergency treatment of post partum haemorrhage	☐	☐	☐	☐	☐	☐	38
6. conservative management of delayed expulsion of placenta	☐	☐	☐	☐	☐	☐	39
7. manual removal retained placenta	☐	☐	☐	☐	☐	☐	40
8. emergency treatment following inversion of the uterus	☐	☐	☐	☐	☐	☐	41
9. infiltration of local anaesthetic prior to repair of perineum	☐	☐	☐	☐	☐	☐	42
10. suturing of perineal trauma	☐	☐	☐	☐	☐	☐	43

7. Please state :-

1 approximate births per annum of employing hospital ☐☐☐☐

2 number of deliveries you have conducted during the past twelve months ☐☐☐

8. **Please circle your highest level of input** in the development of the policies and procedures guiding practice during all stages of labour

1 no input
2 very little input
3 indirect input i.e. formal meetings and discussion
4 direct preparation of policies and procedures
5 involved in determination of policies and procedures

Q.9 With which of the following health professionals (other than midwives and nurses) did you liaise, in the provision of intrapartal care **(Please mark the appropriate box or boxes).**

a. general practitioners (medical) ☐
b. specialist obstetrician gynaecologists ☐
c. paediatricians ☐
d. anaesthetist ☐
e. other than the above medical practitioner (please state)..... ☐
f. social workers ☐
g. psychologists ☐
h. dietitian ☐
i. physiotherapists ☐
j. occupational therapists ☐
k. ministers of religion ☐
l. radiologists ☐
m. pathologists ☐
n. pharmacists ☐
o. other (please state) .....
..... ☐

10. How would you rate the utilisation of your midwifery knowledge and skills in the provision of intrapartum care?
(Please circle the most applicable number).

a. Knowledge

1	2	3	4	5
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised

b. Skills

1	2	3	4	5
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised

11. How would you rate your satisfaction with the division of responsibility for intrapartum care as it affects your role within the health care team?
(Please circle the most applicable number).

1	2	3	4	5
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied

Brief comments on section Four.

SECTION FIVE

Postnatal Midwifery Practice. Clinical, Management, Education or Research.

1. **(Please circle the correct answer).**
Have you been involved in postnatal services during the past five years?

YES NO 70

If answer to Q1 was NO go to last page of questionnaire and add any further comments you would like to make.

If answer to Q1 was YES proceed with Q2

2. Did your postnatal care practice involve :-
(Please mark applicable box or boxes).

a. clinical care ☐ 71
b. postnatal education for the clients ☐ 72
c. education for midwives ☐ 73
d. management of postnatal services ☐ 74
e. research ☐ 75

3. Did your postnatal care include the families of the childbearing women?
(Please circle the correct answer).

YES NO 76

4. **Please mark the appropriate box or boxes** indicating the settings in which you have provided postnatal care in the past five years:-

	Public	Private	
a. Specialist Obstetrician hospital inpatient care	☐	☐	77
b. General Practitioner hospital inpatient care	☐	☐	78
c. Birth Centre	☐	☐	79
d. Alternative Birthing Suite (Attached to a labour ward)	☐	☐	80
e. domiciliary setting (define please)	☐	☐	1
f. other (please state)	☐	☐	2

5. **Please circle** - On a scale 1 to 5 How would you rate your knowledge on the following aspects of postnatal care:-

	Little Knowledge	Some Understanding	Good Understanding	V/Good Understand.	In Depth Knowledge	
a. physiological factors affecting postnatal outcomes	1	2	3	4	5	3
b. anatomical factors affecting postnatal outcomes	1	2	3	4	5	4
c. biological factors affecting postnatal outcomes	1	2	3	4	5	5
d. environmental factors affecting postnatal outcomes	1	2	3	4	5	6
e. psycho-social factors postnatal outcomes	1	2	3	4	5	7

If you have NOT provided direct Postpartum client care please go now to question 7 Page 37.

6. Using the Legend, please indicate at what level of autonomy you have **MOST USUALLY** performed the following activities during the past five years.

LEGEND

A. Assisted with procedure performed by Medical Practitioner
B. Self performed under direct supervision of a Medical Practitioner present at the time
C. Self performed under indirect supervision of a Medical Practitioner following his/her verbal or written orders
D. Self performed following organisational policies and procedures
E. Practiced independently, i.e. autonomous decision making
F. Not practised during the past five years

a. Maternal Postnatal Care

Assessment of immediate post delivery needs

(Please mark one box only).

		A	B	C	D	E	F	
1.	assessment of vital signs	☐	☐	☐	☐	☐	☐	8
2.	monitoring uterine consistency and location	☐	☐	☐	☐	☐	☐	9
3.	monitoring nature and rate of lochial flow	☐	☐	☐	☐	☐	☐	10
4.	monitoring fluid volume	☐	☐	☐	☐	☐	☐	11
5.	identification of post partum haemorrhage	☐	☐	☐	☐	☐	☐	12

		A	B	C	D	E	F	
6.	fundal massage	☐	☐	☐	☐	☐	☐	13
7.	administration of oxytocin or ergot preparations	☐	☐	☐	☐	☐	☐	14
8.	initiation of intravenous therapy	☐	☐	☐	☐	☐	☐	15
9.	bladder catheterisation	☐	☐	☐	☐	☐	☐	16
10.	assessment of trauma to cervix vagina and perineum	☐	☐	☐	☐	☐	☐	17
11.	preparation for evacuation of uterus or surgical intervention	☐	☐	☐	☐	☐	☐	18
12.	assessment of nature and degree of discomfort	☐	☐	☐	☐	☐	☐	19
13.	application of ice pack to perineum	☐	☐	☐	☐	☐	☐	20
14.	provision of comfort and hygiene measures	☐	☐	☐	☐	☐	☐	21
15.	administration of analgesia	☐	☐	☐	☐	☐	☐	22
16.	assessment of family processes and informational needs	☐	☐	☐	☐	☐	☐	23
17.	encouragement of family bonding attachment processes	☐	☐	☐	☐	☐	☐	24
18.	facilitation of early breast feeding	☐	☐	☐	☐	☐	☐	25

b. Continuing monitoring of:-

1.	vital signs	☐	☐	☐	☐	☐	☐	26
2.	fundus and lochia	☐	☐	☐	☐	☐	☐	27
3.	breast comfort	☐	☐	☐	☐	☐	☐	28
4.	perineum	☐	☐	☐	☐	☐	☐	29
5.	discomfort or swelling of the lower extremities	☐	☐	☐	☐	☐	☐	30
6.	surgical incision	☐	☐	☐	☐	☐	☐	31

c. Identification and treatment of complications:

		A	B	C	D	E	F	
1.	haemorrhage	☐	☐	☐	☐	☐	☐	32
2.	infection	☐	☐	☐	☐	☐	☐	33
3.	disease processes	☐	☐	☐	☐	☐	☐	34
4.	excessive breast engorgement	☐	☐	☐	☐	☐	☐	35
5.	mastitis	☐	☐	☐	☐	☐	☐	36
6.	cracked/painful nipple	☐	☐	☐	☐	☐	☐	37
7.	emotional instability	☐	☐	☐	☐	☐	☐	38
8.	psycho/social problems	☐	☐	☐	☐	☐	☐	39

d. Provision of education/information

1.	postnatal self care	☐	☐	☐	☐	☐	☐	40
2.	breast feeding	☐	☐	☐	☐	☐	☐	41
3.	formula feeding	☐	☐	☐	☐	☐	☐	42
4.	infant care	☐	☐	☐	☐	☐	☐	43
5.	community support services	☐	☐	☐	☐	☐	☐	44

Assessment of Infant

e. First hour of life:-

1.	assessment of relevant maternal / family history	☐	☐	☐	☐	☐	☐	45
2.	assessment of relevant prenatal history	☐	☐	☐	☐	☐	☐	46
3.	assessment of intrapartal history	☐	☐	☐	☐	☐	☐	47
4.	apgar scoring	☐	☐	☐	☐	☐	☐	48
5.	assessment of vital signs	☐	☐	☐	☐	☐	☐	49
6.	physical examination	☐	☐	☐	☐	☐	☐	50
7.	detection of abnormalities	☐	☐	☐	☐	☐	☐	51
8.	collection of cord blood for diagnostic purposes	☐	☐	☐	☐	☐	☐	52

		A	B	C	D	E	F	
9.	ordering laboratory tests	☐	☐	☐	☐	☐	☐	53
10.	clearance of airway	☐	☐	☐	☐	☐	☐	54
11.	suctioning of gastric contents	☐	☐	☐	☐	☐	☐	55
12.	maintenance of body temperature	☐	☐	☐	☐	☐	☐	56
13.	administration of oxygen	☐	☐	☐	☐	☐	☐	57
14.	administration of naloxone	☐	☐	☐	☐	☐	☐	58
15.	provision of C P R	☐	☐	☐	☐	☐	☐	59
16.	determining withholding or discontinuing resuscitation	☐	☐	☐	☐	☐	☐	60
17.	preparation for transfer to intensive care	☐	☐	☐	☐	☐	☐	61

f. Family support following birth.

1.	maintenance of safety	☐	☐	☐	☐	☐	☐	62
2.	informing parents of rationale for care procedures	☐	☐	☐	☐	☐	☐	63
3.	promotion of attachment and acceptance	☐	☐	☐	☐	☐	☐	64
4.	facilitation of parent infant interaction	☐	☐	☐	☐	☐	☐	65
5.	supporting parents / families affected by infant morbidity / mortality	☐	☐	☐	☐	☐	☐	66

g. Infant care - 2 hours to 3 days of age

1.	maintenance of thermoneutral environment	☐	☐	☐	☐	☐	☐	67
2.	assessment for hyper/hypo thermia	☐	☐	☐	☐	☐	☐	68
3.	detection of abnormalities	☐	☐	☐	☐	☐	☐	69

		A	B	C	D	E	F	
4.	monitoring and assessment for disease processes	☐	☐	☐	☐	☐	☐	70
5.	referral to paediatrician	☐	☐	☐	☐	☐	☐	71
6.	obtaining specimens for cultures	☐	☐	☐	☐	☐	☐	72
7.	administration of sedatives oral IM IV or SC	☐	☐	☐	☐	☐	☐	73
8.	administration of antibiotics oral IM IV SC or topical	☐	☐	☐	☐	☐	☐	74
9.	assessment of respiratory rate and effort	☐	☐	☐	☐	☐	☐	75
10.	maintenance of clear airway	☐	☐	☐	☐	☐	☐	76
11.	auscultation and assessment of breath sounds	☐	☐	☐	☐	☐	☐	77
12.	observation and recording signs of respiratory distress	☐	☐	☐	☐	☐	☐	78
13.	assessment of presence, location and degree of cyanosis	☐	☐	☐	☐	☐	☐	79
14.	auscultation and assessment of heart sounds	☐	☐	☐	☐	☐	☐	80
15.	monitoring and evaluation of supplemental oxygen administration	☐	☐	☐	☐	☐	☐	1
16.	monitoring arterial blood gases	☐	☐	☐	☐	☐	☐	2
17.	assessment of Hb and Hct levels	☐	☐	☐	☐	☐	☐	3
18.	ordering chest x-ray	☐	☐	☐	☐	☐	☐	4
19.	reviewing chest x-ray	☐	☐	☐	☐	☐	☐	5
20.	weighing infant	☐	☐	☐	☐	☐	☐	6
21.	monitoring blood glucose levels	☐	☐	☐	☐	☐	☐	7
22.	identification of hypoglycaemia	☐	☐	☐	☐	☐	☐	8
23.	initiation of oral feedings breast, gastric tube, bottle	☐	☐	☐	☐	☐	☐	9
24.	monitoring assessment of fluid balance	☐	☐	☐	☐	☐	☐	10

		A	B	C	D	E	F	
25.	identification of feeding problems	☐	☐	☐	☐	☐	☐	11
26.	initiation of IV therapy	☐	☐	☐	☐	☐	☐	12
27.	monitoring IV therapy	☐	☐	☐	☐	☐	☐	13
28.	prevention of cross infection	☐	☐	☐	☐	☐	☐	14
29.	cord care	☐	☐	☐	☐	☐	☐	15
30.	assessment of jaundice	☐	☐	☐	☐	☐	☐	16
31.	administration of vitamin K	☐	☐	☐	☐	☐	☐	17
32.	heel stick testing for PKU	☐	☐	☐	☐	☐	☐	18
33.	assessment of bowel sounds	☐	☐	☐	☐	☐	☐	19
34.	monitor establishment of elimination process	☐	☐	☐	☐	☐	☐	20
35.	identification of gastro intestinal malfunction	☐	☐	☐	☐	☐	☐	21
36.	parent education in infant care	☐	☐	☐	☐	☐	☐	22
37.	provision of information regarding support services	☐	☐	☐	☐	☐	☐	23

h. **Domiciliary Care**

1.	home visits during 1st ten days post delivery	☐	☐	☐	☐	☐	☐	24
2.	post natal maternal care	☐	☐	☐	☐	☐	☐	25
3.	post natal infant care	☐	☐	☐	☐	☐	☐	26
4.	identification of complications	☐	☐	☐	☐	☐	☐	27
5.	parent education	☐	☐	☐	☐	☐	☐	28
6.	referral to community nursing services	☐	☐	☐	☐	☐	☐	29
7.	referral to Medical Practitioner	☐	☐	☐	☐	☐	☐	30
8.	referral to Allied Health please state.....	☐	☐	☐	☐	☐	☐	31

h. **Child Health Services**

		A	B	C	D	E	F	
1.	home visits	☐	☐	☐	☐	☐	☐	32
2.	conducting child health clinics for infants up to 1 year	☐	☐	☐	☐	☐	☐	33
3.	conducting child health clinics for infants up to 5 years	☐	☐	☐	☐	☐	☐	34
4.	promoting family focused health	☐	☐	☐	☐	☐	☐	35
5.	provision of illness prevention measures	☐	☐	☐	☐	☐	☐	36
6.	advising on contraception	☐	☐	☐	☐	☐	☐	37
7.	administer immunisation	☐	☐	☐	☐	☐	☐	38
8.	monitor development of infant	☐	☐	☐	☐	☐	☐	39
9.	assist with family planning	☐	☐	☐	☐	☐	☐	40
10.	other please state	☐	☐	☐	☐	☐	☐	41

7. **Please circle your highest level of input** in the development of the policies and procedures guiding postnatal practice.

1 no input

2 very little input

3 indirect input (i.e. formal meetings and discussion)

4 direct preparation of policies and procedures

5 involved in determination of policies and procedures

42

Q.8 With which of the following health professionals (other than midwives and nurses) did you liaise, in the provision of postnatal care **(Please mark the appropriate box or boxes).**

a.	general practitioners (medical)	☐	43
b.	specialist obstetrician gynaecologists	☐	44
c.	paediatricians	☐	45
d.	anaesthetist	☐	46
e.	other than the above medical practitioner (please state).....	☐	47
f.	social workers	☐	48
g.	psychologists	☐	49
h.	dietitian	☐	50
i.	physiotherapists	☐	51
j.	occupational therapists	☐	52
k.	ministers of religion	☐	53
l.	radiologists	☐	54
m.	pathologists	☐	55
n.	pharmacists	☐	56
o.	other(s) (please state).....	☐	57

9. How would you rate the utilisation of your midwifery knowledge and skills in the provision of postnatal care? **(Please circle the most applicable number).**

a. <u>Knowledge</u>

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	58

b. <u>Skills</u>

1	2	3	4	5	
not utilised	poorly utilised	utilised most of time	well utilised	fully utilised	59

39/

11. How would you rate your satisfaction with the division of responsibility for postnatal care as it affects your role within the health care team? **(Please circle the most applicable number).**

1	2	3	4	5
dissatisfied	little satisfaction	mostly satisfied	well satisfied	highly satisfied

You have now completed the questionnaire - congratulations and thank you very much. Your contribution to this study of midwifery practice in Australia is valued.

Please use the following pages for further comments.

To make this study of even greater benefit to midwifery, in-depth interviews are to be held for a qualitative study which will reinforce the findings of this quantitative survey.
If you feel you have a contribution you would like to make to this part of the study please include your name, address and telephone number at this point. Please be assured of complete confidentiality if you choose to participate.

Yours sincerely

Miriam Cullen

Miriam Cullen.

APPENDIX 3

International Definition of a Midwife

APPENDIX 3

International definition of a midwife

Australian College of Midwives. Standards for the practice of midwifery. Definition of a midwife etc 1 page.

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(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology, 4.12.02)

APPENDIX 4

Practice Settings Visited for Interviews with Midwives

PRACTICE SETTINGS VISITED FOR INTERVIEWS WITH MIDWIVES

New South Wales

King George V
Sydney Adventist
Sutherland
Bankstown
John Hunter
Dubbo
Shell Harbour
St George
Royal Women's
University of New South Wales
Private Practice

Victoria

Royal Women's
St Vincents
Sunshine Campus
Geelong - St John of God
Bacchus Marsh
Private Practice

Western Australia

King Edward Memorial Hospital for Women
St John of God
Armadale Kelmscott Health Service
Curtin University of Technology
Private Practice
Woodside Maternity
Geraldton
Carnarvon
Port Hedland
Nicol Bay
Broome
Wyndham
Derby
Halls Creek
Kunnunara
Newman
Meekatharra

Northern Territory
Darwin RFDS Base
New Zealand - Waikato, Dargaville

APPENDIX 5

Examples of Coded Section of Ethnograph Output

LPHABETICAL List of codewords used in coding NSWTAPES 11/18/1994 19:55

N	CODEWORD	N	CODEWORD	N	CODEWORD	N	CODEWORD
4	ABORIGINAL	1	ANAESTHET	10	ANTENATAL	6	APPRAISAL
1	ATTITUDE	1	AUTONOMY	1	B C MODEL	8	BIRTHCENTR
4	BIRTHSUITE	1	C H N	2	C N S	1	CAESAR
2	CAREERST	1	CAREPLAN	16	CHOICE	1	CLINIC
19	CLINICAL	1	CLINICAT	1	CLININTRA	1	CLINPOST
4	CLINREV	2	COMMEDUC	4	COMMUNITY	1	COMPETENCE
1	CONINFO	8	CONSUMER	11	CONTINUITY	6	DIRECTEN
1	DRG'S	5	E D P	8	ECONOMIC	2	EDUCATION
1	EDUCCLINIC	4	EDUCTERT	3	EMPOWER	2	ENGAUS
2	EPIDURAL	3	EVALUATION	8	EXTROLE	1	FEMINIST
6	G P	1	GRADPR	1	HIGHMORT	5	HOMEBIRTH
20	ID	2	INFORM	1	INFORMMW	6	INSURE
1	ISOLATION	1	JOBDISSAT	5	JOBSAT	2	LABOUR
4	LACTATION	2	LEGAL	1	LEGISLAT	1	LEVEL 1
1	LEVEL 2	5	MANAGEMENT	10	MEDDOM	1	MEDICAL
11	MEDINT	1	MEDLEGAL	21	MEDMID	3	MEDPOL
3	MEDSTUD	1	MIDNURSE	10	MIDPOL	2	MIDPRAC
9	MIDTEAM	4	MIDWIFERY	1	MIDWIVES	13	MIDWOMAN
23	MODEL	1	MODEL COMM	3	MULTICULT	3	MULTISKIL
1	MWCOMM	4	MWEXP	2	MWINT	32	MWPRAC
1	MWREC	3	MWROLE	1	NIGHTST	2	NORMALCY
5	NURSES	1	NURSING	18	OBSTETRICN	8	OBSTNURS
1	P N D	1	PATSAT	1	PEER REV	1	PERSATT
2	PHYSIO	8	POLPROC	2	POSTNATAL	11	PRIVATE
2	PROMOTE	7	PROVNUM	8	PUBLIC	7	Q A
1	REFRESHER	2	REGIONAL	5	REMOTE	2	RESEARCH
2	ROLE	6	ROTATE	1	RURAL	22	SETTING
2	SHARE CARE	9	SHEARMAN	13	SKILLS	7	STAFF DEV
1	STAFFING	1	STRATEGIC	3	STRUCTURE	3	STUDENTS
3	TEAM	5	TERTIARY	1	THEME	1	UNDRADPR
2	UTILIZE	3	WOMAN INF	1	WOMANATT	6	WOMENED
1	WOMENINT						

```
   : +Section 4                                    422 -£
   :   Comments I would like to be instructed      423  £
   :   in and be able to suture.  This             424  £
   :   hospital allows midwives to insert IV       425  £
   :   cannulas after completing inservice         426  £
   :   which I have not yet been able to do.       427 -£
IC---e4325--------+Section 4----------------------------------------VIC   c4

C: SKILLS

-SECTION 4  £-PRIVATE    £-OPPORTUNIT £-OBSTETRICN £-SKILLS
   : +Section 4                                    1691 -£
   :   Comments  I work in the private             1692  £
   :   system, thus the only opportunity for       1693  £
   :   actually delivering a babe is if the        1694  £
   :   obstetrician is late.  However, prior       1695  £
   :   to delivery - all my skills are             1696  £
   :   utilised.                                   1697 -£
-------------------------------------------------------------------------

'IC   c5211        +Section 1

.: %-Q4D

.C: SKILLS

_-C H N      £-SKILLS     £-ATTITUDE   £-OVERSEAS
   :   Comments  I regard myself as a              1952 -£
   :   community nurse with previous               1953  £
   :   midwifery experience, not as a              1954  £
   :   midwife.  My clinical skills have been      1955  £
   :   neglected!  My work as a midwife in         1956  £
   :   Australia was also influenced by a          1957  £
   :   perception (of mine) that overseas          1958  £
   :   trained midwives weren't up to scratch      1959  £
   :   and had to prove themselves.                1960 -£
-------------------------------------------------------------------------

'IC   c4006        +Section 1

:: %-Q4D

3C: SKILLS

:-NIGHT DUTY £-KNOWLEDGE  £-SKILLS
   :   Comments  I 816  ¦  $  ¦
   :   these areas.                                2817  ¦ -$  ¦
-------------------------------------------------------------------------

/IC   c4495        +Section 1

3C: SKILLS

:-SECTION 1  £-COMM AWARE £-MIDWIVES   £-KNOWLEDGE  £-SKILLS
   :   Comments  The degree of initiative          3158 -£
   :   and flexibility granted to midwives is      3159  £
   :   abysmal. Increased public awareness is      3160  £
   :   essential.  In my professional and          3161  £
   :   recently personal experience of             3162  £
   :   midwives, I have found them to be on        3163  £
   :   the whole, a caring, intelligent and        3164  £
   :   astute group of people who in general       3165  £
   :   have a high degree of dedication.  Our       3166  £
   :   knowledge base needs to be increased        3167  £
   :   to match our excellent clinical skills      3168  £
   :   of observation often lacking in             3169  £
   :   Medicos.                                    3170 -£
```

:4706 +Section 1

£-SAFETY £-COMMUNITY
1 We do not have the appropriate 3959 -£
:illary services for midwives to 3960 £
:ctice independently and safety in 3961 £
: community. 3962 -£

Support services

:0045 +Section 1

£-BALANCE
1 Medical intervention at 4085 -£
appropriate times can create 4086 £
oblems and increase need for 4087 £
rther intervention. But for some 4088 £
nen intervention is life saving. A 4089 £
lance is required. 4090 -£

emerg

:4506 +Section 1

£-EDUCATION £-DOCTORS £-COMMUNITY £-NORMAL
1 Education of medical practioners 4120 -£
d the community that as long as a 4121 £
nen is progressing then she should 4122 £
allowed to labour at her own pace. 4123 £
: rate of a labour should not be 4124 £
ctated by the idiom that fast is 4125 £
st. 4126 -£

med - com
unrecog
normal

:4652 +Section 1

£-SETTING
1 This depends on which hospital you 4195 -£
e employed at. 4196 -£

Setting

APPENDIX 6

Personal Profile of Researcher

and

Role of the Research Assistants

Appendix 6

Personal profile of the researcher.

At the time this study was conducted (1992 - 1997) I was a participant in the case being studied i.e. a midwife registered to practise in Western Australia. Prior to undertaking midwifery education at the Curtin University of Technology in 1989 I had practised as a registered general nurse for over 25 years, working in New Zealand, New Guinea and Western Australia. My nursing training in New Zealand, from 1959 to 1962 had included general and obstetric nursing. As a New Zealand obstetric nurse I had practised maternity nursing for 11 years in Papua New Guinea, and 4 years in New Zealand. I returned to general nursing on arrival in Western Australia in 1985, but was keen to practise midwifery again. To gain admission to a midwifery program I completed a Bachelor of Applied Science (Nursing) degree. This was followed by a post graduate diploma in Nursing (Midwifery), leading on to a Master of Health Administration award. These qualifications equipped me to work as a nursing and midwifery administrator, placing me in situations that raised many questions in my mind regarding the practice domain of Australian midwives.

This background in midwifery practice assisted me in gaining entrance to practice settings for the conduct of this study. It also established credibility with the midwives participating in the study. I was asked on numerous occasions whether or not I was a midwife, and was I still practising, before the interviewees relaxed and spoke freely of their own practice and experiences. I believe this has enhanced the findings of this study.

All interviews, data analysis and the development of the conceptual paradigm, together with the writing of the thesis, was the work of the researcher. Advice and guidance was given by the thesis committee with Dr Audrey Martins, as the main supervisor, contributing as a mentor and advisor throughout the conduct of the study.

While personal experiences and knowledge have assisted me in the conduct of the study they have not biased the findings of the study. These have emerged from quantitative and qualitative data collection and analysis following scientific research conventions. It is the contribution of participating midwives throughout New South Wales, Victoria and Western Australia, that has been presented in this thesis, not the views of the researcher.

Role of the research assistants.

Funding from the Commonwealth Department of Human Services and Health enabled two research assistants to provide technical assistance on a part-time basis over a twelve month period. This included the preparation of art work for the questionnaire, distribution of questionnaires, entering data to the SPSS and Ethnograph programmes and computer support in the presentation of the report to the Commonwealth Department of Human Services and Health.

As stated in the acknowledgements Lex Cullen entered the numeric data to the SPSS programme and assisted with the presentation of tables, figures and schema, in addition to providing technical support in the conduct and presentation of the research.

Catherine McKinley assisted with transcribing taped interviews to the Ethnograph, and as an experienced midwife, assisted with the validation of categories during the initial sorting of qualitative data into contextual categories.

The development of the questionnaire, conduct of interviews and field work, data analysis and development of the conceptual paradigm, were not included in the role of the research assistants.

APPENDIX 7

Ethics Committee Approval

CURTIN UNIVERSITY OF TECHNOLOGY

MINUTE TO	:	MS M CULLEN, C/- ASSOC PROF A C MARTINS SCHOOL OF NURSING
FROM	:	MARIE MUNRO, SECRETARIAT
SUBJECT	:	PROTOCOL APPROVAL, HUMAN RESEARCH ETHICS COMMITTEE
DATE	:	18 MARCH 1992

On behalf of the Human Research Ethics Committee I am authorised to inform you that your application for approval of the project "Australaian Midwives' Practice Domain" was approved on 17 March 1992.

Please find attached a copy of your protocol details, and the application form/cover sheet.

The register number for your project is 22/92.

Marie Munro
Secretary
Human Research Ethics Committee

h:\hrecvan\22

APPENDIX 8

Levels of Service Provision

APPENDIX 8

Levels of Service Provision

Australian College of Midwives. Standards for the practice of midwifery. Appendix 1. Organisation of perinatal services etc 3 pages.

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APPENDIX 9

Standards for the Practice of Midwifery

APPENDIX 9

Standards for the Practice of Midwifery

Australian College of Midwives. Standards for the practice of midwifery. Standards 1-4. Professional responsibility and accountability etc 14 pages

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