Midwifery Regulation In Australia: A Century Of Invisibility

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Introduction
This paper examines the status of the midwifery profession in Australia, with specific reference to its legislated context under state based nursing regulatory frameworks, past and present. It provides an historical and contemporary critique of the relationships between midwifery, the state, and medical/nursing institutionalised symbiosis and dominance. Whose interests these relationships silence, and whose they serve is examined, as is their power to influence and situate women’s health and childbearing outcomes in an increasingly global and market orientated environment.

Critique is presented under the following headings:

- Primary Health Care & Midwifery In A Global Context
- The Emergence Of Midwifery In Australia
- Distinguishing Between Community Midwifery & Institution al Medical/Nurse Midwifery
- Contemporary Politics Of Midwifery

The critique advocates reform and innovation that acknowledges a discrete legislated identity and mandate for regulation of the midwifery profession in Australia. This mandate is based on the World Health Organization recognition that midwifery practice is primary health practice and essential to the wellbeing of all women, children and families in society. (1)

Primary Health Care And Midwifery In A Global Context
In many areas of the world there is a resurgence of primary health care for pregnant, birthing and postnatal women and their babies that is midwife led. This is most appropriate, as within the current western scientific paradigm, global evidence to support change has been present for the past three decades, and arguably much longer. (2) In parts of the world where midwifery has been deliberately suppressed or extinguished, the cost to the health system has become unsustainable, and the cost to women's and infants health outcomes unacceptable. In any language the word midwife means "with woman." It is the nexus of this close relationship with women that lies at the heart of all midwifery practice. Inherent in this relationship is the dual values of respect and social support for women, their infants and families, during pregnancy, childbirth and the first months of parenting. Whilst midwifery practice has occurred cross culturally in all human societies for all of human history, it is both a contested site and a gendered site, and cannot be isolated from the specific historical, cultural, social, and political milieu in which it has developed. (3)

In the Australian context it is significant to observe that since white settlement institutionalised midwifery has evolved beside and in relation to medical dominance. Medical dominance has emerged parallel to the development of the nation state. (4) While settlement of the continent of Australia is now only entering its third century. Prior to the arrival of white races with the first fleet in 1788, indigenous groups inhabited this land mass as hunter gatherer societies, having
established themselves here over the past forty to fifty thousand years. Kinship groups were widespread and diverse. The languages of the indigenous population at time of white settlement are said to have been some 750 different dialects, a diversity that was little appreciated or considered in the penal settlements of the English colonists or their European successors. (5) The "Grandmother’s Law" of indigenous women’s birthing practice is a significant component of indigenous social organization that was not understood or acknowledged by white society. Indigenous women’s experience of birth as a sacred and spiritual practice encompassed the notion of the "putari," (name for a traditional midwife of the Ngamindjeri people in South Australia), who was an intrinsic part of indigenous culture and society. (5)

Early ignorance of traditional cultural practices in childbearing, coupled with a continuing failure by the modern nation state to acknowledge "Grandmother’s Law," has resulted in the silencing of indigenous midwifery, social health and women’s knowledge more generally, resulting in medical/state dominance over policy and services that have not enabled indigenous women to pursue self determination in this sphere. (7) This continues to have far reaching implications for indigenous communities. In the year 2000, national outcomes for indigenous populations in Australia are significantly poorer than they are for the white population. On infant mortality rate alone, (i.e.: number of deaths of children under one year of age), the Commonwealth Office for the Status of Women official estimates are 14 deaths per thousand aboriginal and Torres Strait Islander babies, compared to 5 per thousand for white Australians.) (8)

Assimilation policies of early colonial institutions were pursued with vigorous enthusiasm in the early twentieth century and compounded problems. For example, ‘breeding out blackness,’ and removal of children and babies from their kinship networks, ‘the Stolen generation,’ were considered appropriate state endorsed measures for integrating indigenous populations. (9) These practices are historical evidence to support assertions of "cultural racism," that have continued to significantly contribute to ongoing alienation and disintegration of many indigenous families and kinship networks, a process well documented in other cultures recovering from the legacy of colonisation, and further supported by recent insights into birthing services in the Australian context by Stewart, Kildea, and Jag Films. (10,11,12)

Throughout the twentieth century the increasing medicalisation of women’s health in most modern industrial societies is continuing to have significant ramifications for all women. (13) This influence is pervasive, encompassing issues of equity, access and cultural safety in health ‘services’ supported by the state. The impact is evidenced across the spectrum of women’s lives, including the lives of their families and communities, and it is frequently intergenerational. It encompasses the realm of an individuals embodied consciousness, including the powerful link this has with personal wellbeing and health status. It also embraces the collective consciousness, manifesting itself in the social and cultural fabric of systems locally, nationally, and globally. In many affluent Western countries like Australia, expensive technology coupled with medical and nursing expertise that are centralised in large acute care services have undoubtedly contributed to improving reproductive outcomes for some women and their babies. However, it is equally true that many of these technologies and systems remain unevaulated and, that their indiscriminate and continuing application on healthy citizens has caused increasing iatrogenesis for many other women and their babies, the “cultural warping” of childbirth, wastage of scarce health resources, and diminution of the role of midwifery. (14) Such a legacy has already been experienced by a majority of women in indigenous and non indigenous communities in the industrialised world. It now also threatens to engulf the traditional culture and practice of childbearing women in many poorer countries, whom would be better served by access to a basic primary health care resource, i.e.: a midwife. (15)

During the last three decades of the twentieth century childbirth activism movements in many industrialised countries have been instrumental in raising awareness of women’s demand for the humanisation and reform of maternity services, including public policy development that recognizes the short and long term wellness benefits of appropriate maternal care, e.g.: Quebec ASPQ 1981, Winterton Report 1992, Cumberlege Report 1993, Options for effective care in
childbirth 1996, The Mother Friendly Childbirth initiative 1996, Services offered by midwives 1998, New Zealand Health Funding Reforms, in Guilliland 1999, Rocking the Cradle 1999, National Maternity Action Plan 2002. (16,17,18,19,20,21,22,23,24) As governments grapple with implementing sustainable, cost effective public health reform in childbirth, there is resurgent interest and focus on the role of midwifery as an effective primary health care strategy to address Safe Motherhood. At the end of the twentieth century there has been global recognition by the World Health Organization that the midwife is, 

"the most appropriate and cost effective health care provider to be assigned the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications."(25)

Current global evidence overwhelmingly supports a mandate enabling universal access for all healthy childbearing women to midwifery led care. In addition to an internationally accepted definition of the sphere of midwifery practice, countries such as Canada, Holland, Great Britain, Philippines, Malawi, New Zealand, and Germany licence midwives in their own right and regulate midwifery as a discrete profession.(26,27,28,29,30,31,32) However, in many other industrialised societies, including Australia, there has never existed a legislative framework to support the principle of midwifery as a profession in its own right, or universal access to midwifery led care. In fact, many modern nation states, including Australia, have actively supported arrangements that favour continuing medicalisation of birth practices, e.g.: organisational infrastructures, professional indemnification inequities, and discriminatory regulatory and funding mechanisms that perpetuate the status quo. There is abundant evidence of all these state sanctioned mechanisms currently operating in Australia. For example centralized funding and organization of hospital based birthing services in acute care medical settings, government subsidized insurance schemes for doctors, Commonwealth Medicare and private health funding arrangements that privilege medicine and exclude midwifery, nursing regulation that has stymied and silenced the practice, education and professional standards of the midwifery profession.(33,34,35)

The Emergence Of Midwifery In Australia

Midwifery in Australia currently experiences de facto regulation under the auspice of nursing legislation. This position has been historically contingent on acceptance of an identity that has classified midwifery as a branch of specialist nursing practice. It is an identity that is currently under contest, globally, nationally, and locally.(36) At the present time there are no nationally consistent educational requirements for midwifery, nor any nationally consistent practice standards that are universally endorsed by Australian Nursing Regulatory Authorities, including the Australian Nursing Council. Whilst the Australian College of Midwives Incorporated (ACMI), as the peak professional body representing midwives, have articulated national standards for midwifery practice and education, they currently have no statutory mandate to enforce these standards.(37)

Since 1901 Australia has been governed by a constitution that defines the nation as a federation of states and territories. These comprise, New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, Northern Territory, and Australian Capital Territory. Under Australia’s "cooperative federalism model," citizens are subject to both Commonwealth and State/Territory laws. The power of Commonwealth and State/Territory governments to legislate exclusively in certain areas is defined specifically in the Australian Constitution, which also enables the exercise of 'concurrenct' and 'incidental' powers. The provision of services and the regulation of trade and commerce within a state is a state responsibility, that to date has encompassed the area of nursing regulation. Historically state regulation of nursing practice was effected in Australia throughout the early twentieth century, with each state and territory government enacting its own separate Nurses Act. Passage of the 1992 Commonwealth Mutual Recognition Act now enables national recognition of qualifications and freer movement of goods, services, and qualified professionals across state and territory borders, including New Zealand. (38) The significance in all this for midwifery and childbearing women is that de facto regulation of
midwifery, auspiced by Nurses Acts in all Australian states and territories, is inconsistent with the principle of regulation in the public interest.

Within current nurse regulatory frameworks midwifery has an 'assumed' identity as 'specialist nursing practice.' The fundamental anomaly with this assumed position is a broader inference that midwifery practice exists to service the current dominant professional interests of medicine and nursing. These current interests include institutionalised models of pregnancy and birth practice, and a consolidated health infrastructure dominated by these two symbiotic professions. Sponsorship of medicine and nursing by the modern nation state now also embraces alliances with a market driven economy in which health care has been commodified. These relationships have been a disastrous combination for the health of childbearing women in Australia and their infants, and a burden on the pockets of all taxpayers. That midwifery is NOT a rational appendage of the constructs of either medicine or nursing are part of the assumptions and inferences that are being rejected by both women and midwives in the contemporary global renaissance of midwifery practice in modern nation states. (39)

Just as indigenous women's birthing practices were ignored so were those of white women convicts in the colonies. When the first settlers arrived there was a ration of six men to one woman. There were few skilled professionals. Birth for white women, many of whom became pregnant during their journey was a hazardous undertaking. During the convict era and prior to medical consolidation of its authority in the colonies, women assisted each other with childbearing and learnt by virtue of necessity and handing down the knowledge of "women's business," continuing the English 'handywoman' tradition described by Leap and Hunter. (40) Records from 1859 show there were 9 officially listed midwives. As colonial expansion continued, medicine established itself, first through necessity, than as a lucrative paid practice to the establishing middle classes. Hospitals also began to be sponsored by state funds. Some of these establishments commenced earlier as 'lying in' homes for pregnant women who were single or homeless. State funded institutions provided the beginnings of a supportive infrastructure for an emerging medical and market based model of health care. As the state established hospitals throughout the colonies, a labour force to support white, western medical practice was required to staff the institutional model. The appropriation of labour from nurses specifically 'trained' to service this infrastructure and its relationships developed as a tenable solution. Additionally, nursing was considered a 'suitable occupation' for unmarried, white, middle class women. (41)

1862 saw the first 'training' attempts of midwives within the setting of the hospital from a suitably selected group of women whom had first undertaken 'general training' as nurses. Rather than enhancing the skills of the community midwife, an empirical practitioner grounded in what would now be recognized as primary health care practice, this move began the rapid erosion of midwifery skill, autonomy and sphere of practice. The obstetric nurse labelled as "midwife" was effectively moulded, 'trained' to work within the institution of the hospital and a consolidating culture of medicalized birth practice. Dr Jellet's preface to the 1901 publication, "A Short Practice of Midwifery for Nurses," gives an explicit insight into the relationships expected of the parties in systems of medical authority. With regard to the duties of nurse in maternity care,

"Her duty is to give intelligent aid to the medical man when he arrives ...... If she will remember that her work in life is to be a good nurse and not a bad doctor, the temptation to assume responsibilities which she is unable to discharge will not present itself to her." (42)

With organized nursing came organized attempts at state regulation of nursing, the first of these in 1899 auspiced by the Australasian Trained Nurses Association (ATNA) of NSW. The process of regulation marginalized, excluded, and ultimately silenced community midwives, who had not undertaken the prerequisite 'nurse training,' and who were not politically organized in groups such as ATNA. (43) This was a significant lost opportunity for community based midwifery to establish its long term occupational autonomy via a separate legislative mandate. Nursing, taking its lead from medicine, sought to distinguish itself from non-trained practitioners, (including the community midwives), and to establish itself as a closed professional group. James and Willis
(2001) have illustrated how regulation through legislation has been used historically to exclude
and/or restrict the practice of particular occupational groups, stating,
"Registration is the classic strategy of occupational closure." (44)

In Australia, the need to provide a specific labour force to service the requirements of
institutionalised medical birth practice within the hospital setting was effectively accomplished by
incorporating a 'Midwives Register' into the Nurses Acts. In South Australia the bill for the
registration of nurses was introduced in November 1920, and the Nurses Board of SA created.
The Board consisted of nurses and doctors. It should be noted that the early regulatory
authorities for nursing were often chaired by doctors. The first chair in SA was a prominent
obstetrician T.G. Wilson, who had a vested interest and a personal agenda to endorse the
obstetric nurse. It is also of note that in SA, which was not a convict colony but had a majority of
free settlers, 90% of babies were still being born at home at the turn of the nineteenth century.
By 1919 some births still took place at home with community midwives, but the shift to hospital
and a culture of medical birth was well established by the first half of the twentieth century. The
'eclipse' of the community midwives and the forces that marginalised their knowledge was
detrimental to women's birthing experience. (45) State support for nursing regulation that
subsumed and diluted midwifery sphere of practice facilitated this process.

During the second half of the twentieth century, erosion of midwifery practice and education
continued in Australia, assisted by deliberate and systematic redefinition and consolidation of its
identity as a branch of specialist nursing practice. This distortion has been a common trend in
many western industrialized societies last century, and one that is reinforced by both culture and
market interests, as it complements and abets continuing fragmentation and colonization of
women and babies bodies by expensive western science, practice, products and 'health'
systems, across their lifespan. (46,47) In 1970 the professional 'identity crisis' in Australian
midwifery was at last confronted when two British midwives, Maggie Myles and Marjorie Bayes
toured to promote the International Confederation of Midwives (ICM). At this time there was no
national association of midwives in Australia. Membership to the ICM was obtained under the
umbrella of the Royal Australian Nursing Federation in 1972. It took another 6 years to form the
National Midwives Association. In 1978 the name was changed to the Australian College of
Midwives Incorporated (ACMI). (48) There are now branches of the ACMI in all states and
territories, with the national office recently relocated from Melbourne to Canberra in 2003.

**Distinguishing Between Community Midwifery & Medical/Nurse Midwifery**

The model of midwifery that enfranchises women has been silenced in Australia. This section
seeks to make clear the distinction between what is defined as 'community midwifery,' and what
is defined as 'medical/nurse midwifery.' How these 'types' of midwifery practice relate to the
Australian health environment, and hold the potential to either enable or disable women's
experience and outcomes in childbearing is analysed.

Originally, even in Australia, most midwifery was practiced in the community. Initially, community
midwives coexisted alongside their future replacements, the unmarried nurse midwives 'trained'
for hospital based care. Community midwives provided comprehensive maternity care in the
community, and had established relationships with the women and families they served. Though
not 'trained' in any formal sense, these women, who were usually mothers themselves, had an
empirical knowledge and experience of the processes of pregnancy and birth. This included the
identification of social supports, often lacking for poor, single and pioneering women in the
colonies. In rural settlements "Granny Midwives"

Such as Mary Jane Bennett from the Rosewood district of NSW assisted many babies into the
world, "travelling miles on horseback on her journeys to women facing cliffs, rivers, flooded
creeks, mountain steeps and dark valleys in the saddle." (48) Lay midwives by the standards of
today, these remarkable women fulfilled the role of midwife during pregnancy, birth, and the early
'lying in' period. The contemporary definition of community midwifery is that of a social model of
birth that is woman centered, publicly funded, and located in the places where families live and work.

It is asserted that the regulation of midwifery as specialist nursing practice fostered the professional and cultural evolution of medical/nurse midwifery, which has become the servant of institutionalised birthing practice in Australia. Maternity “care” delivered within this model is fragmented, episodic, and occurs in the wards and departments of centralized health bureaucracies and hospitals. This “care” is centrally located within the medical paradigm and usually involves the application of complex technologies that objectify and dehumanize women and their infants. This model is the legacy and product of western imperialism, the rational doctrines of the Enlightenment, and modern mechanisation. Within these systems, women, infants and midwives are seen as secondary. They are objectified as “other” and alienated from both their bodies and the social determinants of health identified in policy such as the Ottawa Charter. (50) Ongoing sponsorship of this model by the modern nation state through health funding mechanisms, infrastructure support, and current regulatory arrangements makes the relationship between nursing and the regulation of midwifery practice highly significant.

Support for a regulatory framework that classifies midwifery as specialist nursing practice is a state sanctioned mechanism enabling maintenance of current labour force and system infrastructure to meet the needs of institutionalised medicine. Institutionalised medicine is in turn becoming more specialized and fragmented in relation to laying claim to various aspects of birthing women and babies bodies, e.g.: feto-maternal medicine, obstetrics, neonatology, paediatrics. Unsurprisingly, perverse similarities in specialization and fragmentation are occurring in nursing in the United States, where ‘health maintenance’ organizations are sponsoring providers such as obstetric nurse practitioners for antenatal care, nurse – midwives for intrapartum care, maternal & child health nurse practitioners for the postpartum episode, and reproductive nurse specialists for ‘contraceptive care.’ (51)

Shoebbridge’s sociological analysis of the state of midwifery in Australia in 1979 and 1989 show clearly how midwives capacity to provide holistic, humanized, community based birthing services desired by women are inhibited by economic, professional, social, industrial and bureaucratic structures whose scope and shape are the deliberate product of structured power relations and vested interest. (52,53) A lack of infrastructure supporting mainstream implementation of community midwifery models in Australia has arguably contributed to the evolution of a class of providers called Independently Practising Midwives (IPMs). These midwives have rejected employment in the medical/nurse midwifery model and privately contract their services to women in the community. “The definitive characteristic of independent midwifery is that the midwife’s primary allegiance is to the woman and family who have engaged her in service, not to the state, or to any private employment contracts regulated by others.”(54) Despite childbirth outcomes that are superior to state outcomes across a range of indicators, in recent years IPMs have been increasingly marginalised by withdrawal of their clinical privileges and visiting access at state hospitals and Birth Centres, withdrawal of access to appropriate professional indemnification arrangements, and high profile court cases and Nurse Tribunal findings that have been described as “modern day witch hunts.”(55)

In the past ten years government policy to address a growing demand for access to community midwifery services by Australian women has been limited to the Alternative Birthing Services Program (ABSP). (56) Nearly all states and territories have now piloted some form of community midwifery project. The majority have demonstrated success regarding outcomes, cost effectiveness, and care preferences by women. Whilst ABSP enabled the development of pilot projects to trial ‘alternative models’ of birthing services, as a policy initiative it has failed to deliver the major health system reforms and mainstream change required to enable universal access to midwifery led care for all Australian families. These themes, particularly the relationship between midwifery and nursing regulation have been taken up by a number of writers in the 1990’s. These writers now openly challenge continued state and statutory endorsement of the “invisible
midwife, in favour of visible, transparent regulation that names the practice of midwifery and ensures universal legislated state access to midwifery models of care. (57,58,59)

Contemporary Politics Of Midwifery
Childbirth has always been political. The fields of education, regulation, industry, and community interest, are all critical sites in which the contemporary politics of midwifery is currently being debated in Australia. That midwifery is a contested site, and that language is a primary medium of that contest is evident in the discourse. Kahn articulated the notion of language as an instrument of control, describing it as, “the repository of all power relations.”

What midwives name themselves and their practice is of increasing significance, with the importance of nomenclature distinction in nursing and midwifery having been well described by White, Leap, Brodie and Barclay. (60,61,62) The process of emancipation for midwifery within the context of numerical dominance by the nursing profession has fostered a culture of horizontal violence that is also evident within these fields. Within this culture midwives and women’s voices have been silenced. That silence is now breaking open.

Social change is promoting and challenging current regulation based on nursing to identify the discrete practice that is midwifery, and to legislate it visibly and representatively. Recent change to midwifery education and models of practice also demand this issue be addressed as a matter of urgency. Publication of the three year Australian Midwifery Action Project (AMAP), a collaborative investigation by ACMI, University of Technology Sydney, several health authorities and industry partners, which included Women’s Hospitals Australia, constituted a comprehensive analysis of issues in all these areas. Recommendations on midwifery education, regulation, implementation of midwifery models, and community consultation have been made, and now await implementation. (63)

The formation and replication of grassroots organisations calling for reform to birthing services and current state arrangements, have also steadily been increasing their profile in the Australian community over the past decade. (64) One of these organisations had its origins in South Australia in 1997, when community members and midwives came together to lobby for discrete recognition of the midwife in legislation as part of that state review of its Nurses Act. Whilst the organisations initial aim was not achieved, it evolved to become the Australian Midwives Act Lobby Group (AMALG), who have articulated a Vision Statement and Terms of Reference based on principles of community and midwifery partnership to achieve the goal of nationally consistent midwifery regulation.

Over the past six years the activities of AMALG have been instrumental in increasing public awareness of the role of the midwife, and in demanding greater accountability from educators, regulators, industry, and the nursing and midwifery professions for appropriate midwifery standards. Throughout its lifetime AMALG has conducted public forums, demonstrations, media interviews, conference presentations, coordinated petitions, participated in Competition Policy Review and given evidence to Federal Senate Inquiry’s. (65) Members of the group have written submissions for review of four state and territory Nurses Acts, met with politicians, professional groups, community groups, circulated a National Commentary Paper, published principles for a draft Midwives Bill, launched Midwifery Education packs for use in SA schools, participated in state government reviews of birthing services, lobbied for publicly funded models of midwifery care, and consolidated a formal affiliation with the national Maternity Coalition Incorporated. Most recently AMALG has supported the launch of the National Maternity Action Plan, assisted the Choices in Childbirth campaign, and completed a submission for review of the Medicare Agreement. Organisations such as AMALG, Maternity Coalition, Association for Improvement in Maternity Services (AIMS), in partnership with professional midwifery bodies and women, will ensure a proactive approach to midwifery regulation is kept on the state agenda.

Well educated midwives are essential to guarantee that a high degree of support, safety, and satisfaction is afforded to the childbearing population of any society. The lowest mortality and morbidity rates for women and babies are recorded in those countries with a recognized, well
educated and regulated midwifery profession. Close to home the New Zealand experience demonstrates powerful improvements in health outcomes for Maori women and their infants since the introduction of legislated universal access to midwife led care. (66) Attempts have recently been made to meet international standards in the education of Australian midwives by introducing a three year Bachelor of Midwifery Degree at several Australian universities. Additionally, it is projected that this strategy will help to address current industry shortages and an ageing midwifery workforce. (57) It is of note that applications for the inaugural programs at two South Australian universities for 60 places exceeded 600 applications. The first cohorts of these midwifery graduates will be eligible for registration at the end of 2004. They are persons who have not been educated as nurses, and who have a commitment to practicing midwifery in midwifery models of care. Currently the only mechanism for their regulation is under Nurses Acts via a 'conditional' nursing licence/registration that is limited to the area of 'midwifery.' This legislative ambiguity is problematic for the nursing profession, the midwifery profession, and the general public.

An additional educational and regulatory conundrum is the current 'diverse options' for postgraduate nursing specialization in the 'field of midwifery' within Schools of Nursing. Arguably some of these programs fragment and dilute midwifery practice within nursing frameworks that impede recognition, adoption, and implementation of basic competency requirements to practice in accordance with the internationally defined sphere of midwifery practice. (68) The first principle of professional regulation through legislation is that it should be in the public interest, (COAG Committee on Regulatory Reform 1999). (69) The public interest of naming WHAT is being regulated surely cannot be overstated. A pragmatic way to resolve these concerns is through endorsement of national professional standards for midwifery education and practice. This must occur within an appropriate legislative framework that enables the application of consistent principles in midwifery regulation across all Australian states and territories. These principles are essential to any credible process in assessing applications for registration from midwives who have qualified in overseas programs. As New Zealand midwives prepare to be registered in their own right under the new Health Practitioners Competence Assurance Act, this will pose additional challenges for Nurse Regulatory Authorities in Australia, to comply with mutual recognition requirements.

Two other issues currently challenging efforts to introduce publicly funded community midwifery models in Australia include implementation of the 1998 National Health & Medical Research Council recommendations in ‘Review of services offered by midwives,’ and the constraints inherent in current industrial conditions and pay Awards for Nurses. The NHMRC recommendations have acknowledged what is already current midwifery practice in the public sector. It is now crucial to the success of community models that midwives are legitimately authorised to undertake pathology and diagnostic imaging, prescribing, and referral as part of normal pregnancy care and the sphere of basic midwifery practice. (70) Current attempts to claim these features as ‘extended practice’ and to regulate them under the guise of Nurse Practitioner frameworks is a nonsense, and yet a further attempt to subsume basic midwifery practice under a nursing conceptual hierarchy of ‘advanced practice.’ Similarly, attempts to employ midwives under state based Nursing Awards that currently service institutional requirements are inappropriate for models that require the flexibility offered by an Annualised Salary Agreement.

Recent collapse of one of Australia’s largest Medical Defence Funds and the crisis in securing professional indemnification for midwives and doctors, has challenged the ongoing viability of privatised obstetrics in Australia. With this has come increased media attention on all birthing services, particularly the absence of services for rural and regional women. An increasing profile of midwifery and the primary health services offered by midwives is building in the community psyche, and with this will come an increasing demand for visible, transparent regulatory practice.

Conclusion
Midwifery practice is primary health practice and essential to the well being of childbearing women, their infants and families. The history of Australian midwifery since white settlement has
been one of erosion and colonisation by powerful “others,” including medicine, nursing and the nation state. This has resulted in the erosion of women’s birthing power, and state and statutory endorsement of the “invisible” midwife. In the twenty-first century, social change that includes political alliances between the community and midwives is driving a reform agenda and public service innovation that demands a discrete legislated identity for the midwifery profession. This framework should be based on national standards for midwifery education and practice that are underpinned by the internationally defined sphere of midwifery practice. Such a framework is possible via a number of mechanisms:

*uniform amendment of current nursing legislation to enact joint Nurses and Midwives Acts in all Australian states and territories;
*statutory establishment of distinct Midwifery Regulatory Authorities / Councils in all Australian states and territories;
*Health Practitioner Omnibus legislation that identifies midwifery as a discrete practice in all Australian states and territories.

Midwifery has and will always exist. In the twenty-first century it will write itself back into legislation, history, and the lives of women and families around the world, including Australia.

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