This is the published version of a paper presented at the Australian Nursing Federation’s Conference on *Autonomous practice in nursing and midwifery: independence and partnership*.

Please cite this article as:


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This paper examines the status and some of the issues surrounding autonomous midwifery practice in South Australia in 1996. It is based on the author's reflections and lived experience as an intermittently self-employed midwife practitioner within the Adelaide community during the past three years. Additionally, the paper examines recent national and state reports and recommendations on the maternity services. The principal themes that will be explored include: personal, professional, structural and cultural challenges in achieving autonomous midwifery practice. Whilst explicit exploration of the theoretical orientations underlying this paper are absent, the primary influence are those of critical theory, (particularly the works of Michel Foucault, 1971, 1973, 1976, 1977, 1980), and socialist feminist theory, (particularly the work of Alison Jaggar 1983).

INTRODUCTION

In reflecting on the challenges encountered in my own experience of autonomous midwifery practice I have endeavoured to both enliven and balance the viewpoints presented, by constantly returning to the two broaden themes to this conference, independence and partnership.

Independence implies the autonomy of singularity that is irrevocably bound to individual human embodiment and ego. It encompasses self assertion, self reliance, the freedom to exercise judgement and choice of action without interference of subordination to others (Hayward 1982). As any mother will attest, independence finds pure, exasperating expression in the unrestrained “I” of a wilful toddler!

The other major theme, partnership, by necessity entails a relationship between distinct identities. At the very least this involves a relationship of duality. However, as societies become ever more complex, these relationships, (or so the post modern theorists tell us), are evolving into dimensions that reflect multiplicity (Gunew and Yeatman 1993). The foundations upon which a partnership is built and maintained is therefore very influential in determining the interests, dynamics and direction of a relationship. Optimally, I believe true partnerships both celebrate and tolerate difference between identities. They do not seek to manipulate, subordinate, annihilate, exploit, or in any way diminish the other. In a healthy relationship, partnership finds expression through dynamics premised on sharing and interdependence. This is reflected in relations of reciprocity between mutually respectful parties, each secure in and with their own discrete identity.

MIDWIFERY IDENTITY AND SCOPE OF PRACTICE

The identity and scope of practice of midwifery is articulated and endorsed at an international level by the International Confederation of Midwives, the World Health Organisation, and the International Federation of Obstetrics and Gynaecology:

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"A midwife is a person who, having been regularly admitted to a midwifery educational 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 practise midwifery. She 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 preventative 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 the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units. Domiciliary conditions or in any other service."

Midwifery is a profession involved with the promotion of women’s health. Therefore, as is inherent in the term ‘midwife’, care takes place in partnership, ‘with women.’

"The midwifery philosophy of partnership with women facilitates appropriate decision making based on shared information and informed consent," (pg 45 NZCOM 1993).

Additionally, midwifery scope of practice acknowledges a primary health, wellness model and social view of pregnancy and childbirth as part of the normal life experience of most women. Midwifery also recognises the individuality of each woman’s needs and experience during this significant pathway of life change (Oakley and Houd 1990).


Continuity of midwife care is care provided through,

"antenatal, labor, birth and the postnatal period, by a named Midwife of Midwives with whom the woman has had an opportunity to develop an intimate relationship."

(pg 45 NZCOM 1993).

It is this point about the nature of the particular relationship, including the terms of the relationship, between a woman and her midwife that for me provided the principle motivating impetus to move away from occupying the spaces mainstream maternity service delivery offered, and into independent midwifery practice.

Within most mainstream maternity services the midwife’s role has been eroded and fragmented to the same degree as women’s experience of pregnancy, childbirth and motherhood has become dismembered and compartmentalised into discontinuous “episodes” of care, centred around the needs of institutionalised systems, funders and professionals. Within this framework, artificial divisions are constructed around women’s experiences and body’s, dissecting these into discrete antenatal, labour and delivery, and postnatal episodes, which extend further into the realm of motherhood and child health care. This bizarre framework typifies Western medical systems based on illness models. Such a
framework exists not for the benefit or empowerment of women. Contemporary research into women’s experiences of pregnancy and childbirth within such systems clearly demonstrate the contrary (Simkin 1992, 1991; Green, Coupland and Kitzinger 1990; Graham and Oakley 1981; Oakley 1984, 1980, 1979). Rather, it can be accounted for as the interplay and result of a combination of powerful cultural, structural, professional and personal factors. It is important to recognise that these factors often do not operate as distinct categories, but intermesh and influence each other at many differing intersections within individuals and the broader society.

OVERVIEW OF AN INDEPENDENT MIDWIFERY PRACTICE

Before embarking upon a personal reflection of these four challenges to autonomous midwifery practice and changing childbirth in South Australia, a brief overview of my scope of practice over the past three years is warranted.

Upon completing a hospital-based training programme in midwifery in Adelaide in early 1993 I was very disillusioned with the prospect of continuing to practice and participate in what I perceived and experienced as fragmented systems of maternity care, responsible for perpetuating excessive rates of obstetric intervention. Neither did these systems offer the prospect of fully developing or utilising my beginning practitioner midwifery skills.

Around this time, to bolster my flailing spirits I became involved with the South Australian Independent Midwives Association. This small group of independently practising Midwives mainly attended homebirths, but some also had practising privileges within certain Adelaide hospitals and Birthing Centres, and others were involved with a community pilot project in continuity of midwifery care funded under the federal Alternative Birthing Services Initiative. To a fledgling, these Midwives, whilst functioning at the margins of mainstream maternity services, constituted powerful role models of Midwives truly practising and utilising the full range of their skills to offer women continuity and care alternatives. I strongly acknowledge the powerful influence and leadership of such visible practising role models providing support and courage to the fledglings of the midwifery profession who fly along behind them.

Contemplating my own first pregnancy and seeking to explore the full range of options I could consider personally, also stimulated involvement with several consumer groups focused on birthing services in South Australia. Over the next twelve months I undertook hospital based postgraduate clinical experience in midwifery and moonlighted with four accredited Imp’s as their ‘apprentice/support midwife,’ participating in continuity of antenatal and postnatal care and attending planned homebirths.

Eight months following the birth of my own daughter at home - a very affirming experience that strengthened my resolve regarding the benefits of continuity of independent midwife care, I began and have continued to take on my own primary caseload of 1-2 women per month with the support and preceptorship of several accredited Imp’s. Additionally, I provide secondary care as the “support/backup midwife” for approximately 1-2 births per month where these Imp’s are the primary caregivers.

The sphere of practice,

“takes place within a private contractual agreement between the midwife and the woman and is conducted independently and independently in accordance with the Australian college of Midwives Incorporated 'Standards for the Practice of Midwifery,'”
This scoop of practice involves the provision of continuity of midwife care during the antenatal, labour and delivery, and postnatal period, for women, their babies and families.

The bulk of my caseload entails families choosing homebirth, currently a very small segment of the community. In South Australia over the past 5 years planned homebirths comprise between .2 - .3 % of all births (SA Pregnancy Outcome Unit 1990 - 1994). This is slightly lower that the national average of .5 - 1.0 % for homebirths (Bastian and Lancaster 1990).

Guidelines and policy relating to a woman’s suitability for homebirth are outlined in the Report of the South Australian Birthing Services Working Group (SAHC 1994). Contrary to popular opinion Imp’s do not work in isolation. They consult with a full spectrum of health professionals. In accordance with National Health & Medical Research Council guidelines (1992) a back up hospital booking is made antenatally for all planned homebirths to cover the possibility that complications may develop later in the pregnancy. At this time the woman is reviewed by a senior medical officer skilled in the practice of obstetrics. Should intrapartum or postpartum transfer of mother or infant be indicated, (in which case I accompany the family to hospital, continuing on as their support and advocate), the transition is smoother and communication and information flow is unimpeded.

Increasingly, I am experiencing requests from women for a variety of arrangements. The family may for example, seek antenatal share - care between myself and their general medical practitioner or obstetrician, or wish to birth in hospital or a Birth Centre, but with continuity of care from a midwife with whom they have established a trust relationship. This relationship extends into the postnatal period and encompasses assistance with issues such as breastfeeding, infant care, family planning, parenting and psycho - social - emotional well being. The accessibility of such arrangements however varies significantly, often depending more upon the ingenuity, negotiating skills and resources of a family, rather that upon professional or structural supports, as I will describe later in the analysis.

Within the schedule of fee guidelines developed by SA Independent Midwives Association (1995) the approximate cost of comprehensive continuity of midwife care is around $1300, although fees are negotiated on an individual basis and vary according to circumstances, travel distances, and care provided. Most visits take place at the woman’s home and incorporate elements of education and information sharing. Generally these occur at four weekly intervals throughout pregnancy and more frequently as the birth date approaches, depending upon the families needs. Visits last between half an hour to several hours. Continuous care is provided for the woman throughout established labour and birth, in the later stages with the support of the “back - up midwife”. After the birth I visit the woman again within 24 hours and arrange for the infant to have a medical examination at home, usually with the families local GP. I continue daily visits for 5-7 days, call again around three weeks, and am on call until the infant is 28 days old. A six week check of mother and babe concludes the formal relationship, although I generally have social follow-up at three and six months. The nature of the relationship however often means that friendships develop and contact continues long beyond these time frames.

Some of the advantages of having your own midwife include:

- Getting to know your midwife before the birth
- inclusion of children and friends
- access to information
- continuity of antenatal, labour/delivery & postnatal care
- responsibility/self determination for your birth experience
- time to discuss ideas and feelings in your environment
• guidance and support for your decisions
• comfort of your own home and bed
• breastfeeding support and advice
(SAIMA 1994)

Another advantage to continuity of independent midwifery care is that obstetric interventions and morbidity are significantly reduced. To conclude this section a summary of outcomes for 30 births attended during the years 1994 - 1996 is provided. Fifteen of these births involved my participation as the “back-up midwife,” and were attended by one of five independently practising Midwives. The other fifteen births I attended as primary midwife, supported by an IPM.

90% Spontaneous Vaginal Delivery Rate (ie: 27 births)
10% Caesarean Section rate (ie: 3 births)

All births apart from one were planned homebirths.
25 births took place at home
11 of these women were birthing their first baby
9 women expecting a first baby experienced SVD
7 births of the total were water births
24 intact perineums (nil episiotomies)
2 first degree tears (unsutured)
1 second degree tear (sutured)
1 placenta accretia (manually removed in hospital)
1 postpartum haemorrhage (800 mls managed at home.)

Of the 5 transfers to hospital:

1 was for epidural pain relief
1 was for prolonged labour > 30 hours
1 was for repeat caesarean section
1 undiagnosed breech presentation resulting in caesarean section
1 prolonged rupture of membranes > 100 hrs, resulting in caesarean section following unsuccessful induction.

All infants had apgars of 9 or greater at 5 minutes apart from one, (ie: prolonged labour > 30 hours). This infant had an apgar of 7 at 5 minutes and was weaned from cot oxygen at 20 hours. All infants were breastfed for three months or greater.

CULTURAL CHALLENGES

One of the broadest and most resistant challenges to autonomous midwifery practice in South Australia is the cultural constraints imposed by the dominant health beliefs and patterns of service delivery, common to modern western industrialised societies. Maternity service and public perception do not exist or develop in a cultural vacuum. They are a reflection of broader relationships of power that have become embedded in popular culture at personal, social and institutional levels (Carr and Kemmis 1983, Marcuse 1964). In Australia, dominant health are relationships are based on tenets of positivism and medical/scientific ways of knowing (Willis 1989, Turner 1987, Russell and Schofield 1986).

In South Australia, the culture of maternity care that is promoted and made accessible to the vast majority of women is hospitalised care provided within public or private institutionalised settings. It is asserted that these services reflect the dominant techno-medical culture in Australian health care,
including the economic and professional interests that surround medicalisation of women’s bodies and experiences in childbirth and motherhood. These services characteristically fragment women’s relationships and experience of pregnancy, childbearing and motherhood. Despite this, a majority of Australian women continue to utilise these services and there are strong moral and social sanctions when they do not (Crouch and Manderson 1993).

Whilst the number of women delivering in birthing Units funded under the Alternative Birthing Services Program has increased fourfold since its commencement in 1992, the majority of women in SA continue to attend hospital antenatal clinics and to birth in hospital labour wards. Statistics for 1994 show 49% of women delivered in teaching hospitals, 27% in metropolitan private hospitals and 24% in country hospitals. Of this total, 39% were private patients (Pregnancy Outcome Unit SA 1994).

Obstetric intervention rates in SA are well above those recommended by the World Health Organisation (Wagner 1994). In 1994 the spontaneous vaginal delivery rate for women in SA was only 63%, 24% of women had labour induced, and a further 24% had spontaneous labour augmented. Epidural anaesthesia was utilised for pain relief and delivery for 41% of women, episiotomies performed on 20%, and caesarean sections on 24% (Pregnancy Outcome Unit SA 1994). Private accommodation in hospital is also associated with significantly higher caesarean rates in this state and in Queensland (Lancaster 1994). Whilst the Perinatal mortality rate remains the lowest recorded (9.8 per 1000 births in 1994) it is more than three times higher for aboriginal babies (Pregnancy Outcome Unit SA 1994). Whilst some would argue that intervention rates reflect contemporary women’s choices in childbirth, (eg: ‘pain free’ labour, social inductions), others attribute them to community expectations for a perfect outcome, (ie: a healthy baby), from every pregnancy (Hailstone, The Advertiser 30/3/95). Whichever the case, recent state reports and ministerial reviews of birthing services in Australia that have incorporated extensive public consultation, argue for urgent changes to our maternity services (NHMRC - Options for effective care in childbirth 1996, SAHC Models of Maternity Care Working Party Report 1995, ACT Maternity Services Review 1993, Office for The Status of Women - The New National Agenda for Women 1993, Having A Baby in Victoria 1990, Ministerial Review - WA Department of Health 1990, Congress Alukura, Shearman Report 1989).

The concerns consistently raised by women in relation to care in childbirth remain: safety, control over birth process, access to and sharing of information, and continuity of care (Paul 1994).

If one returns to the identity and scope of practice of the midwife, it is arguably this practitioner, utilising the full range of her skills who could do much to address the changes that women are seeking (Page 1995). For such changes to occur in Australia, I would argue that the wider public perception of the midwife’s role requires a cultural shift from her location and fragmented role within hospital bureaucracies to a more continuous “wellness” focused role in the community.

As a cautionary note in relation to culture I would add, that in my experience of birthing services there can be no assumptions or broad generalisations about what women’s needs in childbirth are. Systems and services that attempt to lump all women together as an undifferentiated, homogenous group perpetuate dissatisfaction.

Individual women’s needs and expectations are very diverse, varying across age, class, cultural background, education, sexuality, life experience, personality and family dynamics. What women as a group are seeking is diversity of care options in childbirth.
The development of the midwife’s role in SA remains constrained due to many structural barriers that reinforce dominant medical models of service delivery and limit women’s options for care. At a material and practical level, structure dictates the form and accessibility a population has to services. Whilst the former federal government’s Alternative Birthing Services Program has enabled development of some innovative projects in SA, (e.g. four public birthing units in metropolitan Adelaide, Dale Street Community Midwifery Pilot Project, Maternal and Neonatal Ambulatory Care Project), more specific and national reform to the organisation and funding of maternity services is urgently required if real options and sustainable mainstream change are to occur.

Many of the structural issues revolve around the need for integrated service delivery. Some of these issues have recently been addressed in both the NHMRC document, Options for effective care in childbirth 1996, and the SAHC Models of Maternity Care Working Party Report 1995. Included are recommendations for the development of a variety of shared-care models of practice between Midwives and other professionals that facilitate continuity of care and culturally sensitive care. Also included are recommendations for delineation of visiting privileges for accredited Midwives within hospitals and birthing units. Currently when I transfer into hospital with a family my status changes from ‘midwife’ to that of ‘support person,’ and at an official level I am unable to continue on as the family’s principal carer. At a public level despite a philosophy based on continuity of midwife care, many birthing units are struggling to implement this in practice, due to limited resources and the constraints of work environments and industrial regulations that impede midwifery caselading, (personal communications BC Midwives 1996, Dale Street Community Midwifery Report 1995 - Unpublished).

Despite the rhetoric and recommendations of recent reports supporting the need for alternative models of care, funding and professional indemnity arrangements are two of the principal factors that continue to perpetuate inequities in maternity service arrangements.

Currently, there are no Medicare rebates for midwifery care. Whilst some private funds rebate a portion of the care, it is only in the vicinity of $400. Cost is a substantial disincentive to many families who would otherwise access midwifery services. This “option” is only accessible on a private fee for service basis to those women and families who can afford to pay for it.

Unless the midwife is a salaried employee of the state, prohibitive indemnity insurance arrangements make visiting privileges within SA hospital inaccessible. Currently the level of insurance recommended by the SA Health Commission for an IPM is $20 million per annum, an unobtainable level of insurance which the estimated premium is $15 000 annually (Hope Island Insurance Brokers Pty Ltd 1994). Therefore the option of birthing in hospital of a birthing unit with continuity of care from an independent midwife is also restricted.

Proposed legislative changes to the Nurses Act of SA 1984 will also, I believe, have significant structural ramifications, for child bearing women’s options for care. Proposals by the current Nurses Board of SA to delete the midwifery register and omit specific midwifery practice legislation within the revised Act both flies in the face of international trends and will result in further fragmentation of maternity services and increasing morbidity where child bearing women are no longer guaranteed the care of a qualified midwife (Review of the Nurses Act, NBSA, July 1996).
PROFESSIONAL CHALLENGES

In 1993 Barclay pointed out,

"In Australia today, Midwives are less likely at a regulatory level to be dominated by medicine than nursing. The consequences may be subtle but are no less real."

Recently I have been wondering about the degree of subtlety that is sustainable when the identity and practise of one group is continually under threat of absorption and control by another.

The history of nursing and midwifery in Australia has been inextricably intertwined at cultural, structural, professional and personal levels for both nurses, Midwives and the broader public. There are some who see the continuation of these unchanging ties as both necessary and desirable, and others, like myself who believe that whilst there will always be links, redefinition of the terms of the relationship between nursing and midwifery is not only healthy but has already commenced, and will continue to develop local, national and international levels well into the 21st century.

The professional organisation representing Midwives and midwifery practise in Australia is the Australian College of Midwives Incorporated. In reviewing the history of the ACMI in 1991, Peters saw the organisation experiencing a phase of development she likened to, “the troublesome and turbulent teens.” If Midwives and midwifery practice continue a healthy development to “come of age,” in this country then I would argue that diversity of options and autonomy in professional identity, education and practise is essential for both nurses and Midwives.

Recent NHMRC recommendations on Options for effective care in childbirth 1996, recognise midwifery as a discrete practise and propose a review of the membership of the Australian Nursing Council (ANC) to ensure adequate midwifery representation.

The opportunity also currently exists in this state for a proactive legislative review in relation to midwifery practise. The NBSA have the opportunity, in conjunction with the SA Branch ACMI to propose an innovative Nursing and Midwifery Act that acknowledges the mutually specific identities of nursing and midwifery, (including scope of practice), and provides equitable opportunities for registration of Midwives educated via pathways alternative to nursing, (eg: Direct Entry). As Wagner (13/8/96 in correspondence to Dr Armitage, Minister of Health, SA) has recently pointed out,

"there is a strong global trend away from requiring that Midwives also be trained as nurses and away from having midwifery regulated by a Nursing Board."

Examples of countries with direct entry midwifery programs include: England, Wales, Denmark, France, Netherlands, Belgium, Germany, Eastern European countries, Canada, and 20 American States.

At the level of individual autonomous midwifery practice there are many professional challenges. One in particular is the limited opportunities available to student Midwives for skill acquisition through preceptored clinical practice with an IPM. This is problematic since difficulty is then encountered in fulfilling ACMI accreditation / credentialling guidelines. Other issues include: current socialisation and consequent deskilling of many experienced Midwives into fragmented roles, and absence of prescribing rights for Midwives, the need to develop research-based practice, a need to develop quality assurance mechanisms and strategies for ongoing education, and maintenance of both professional and consumer networks / partnerships.
PERSONAL CHALLENGES

As the conclusion to this paper I decided to offer some personal reflections on the rewards and costs of autonomous midwifery practice as I have experienced them.

On the positive side there is the satisfaction that comes from working in partnership with women and being able to offer real continuity of care for families. Child bearing is not simply an event or episode in a woman of families live. It’s an ongoing process and a time for great change and growth. Sharing in this process is a privileged position, enabling the development of meaningful relationships and the utilisation and constant development of a full complement of midwifery knowledge and skill. Such a sphere of practice is interesting, challenging and empowering, both for women and midwives. In terms of the relationship between power and knowledge it places the locus of control firmly with women, enabling them to write their own child bearing scripts at both the personal and cultural levels. The implications of this world-wide trend towards reclamation and revaluing of “women’s knowledge and power,” and its benefits to individuals and the wider society can never be underestimated.

Whilst autonomous practice offers the flexibility of being self-employed, this also comes at a certain cost. There is the uncertainty that accompanies insecurity and irregularity of income. Additionally, the physical, mental and emotional demands of being accessible to women and their families 24 hours a day can be taxing both personally and to one’s family and social life. As with all things balance is crucial. The need to take time out to physically, mentally and emotionally nurture oneself and one’s family is essential.

The level of responsibility in autonomous midwifery practice is always felt acutely. Equally acute must be the awareness and recognition of one’s own personal and professional practice boundaries. The capacity for deep intimacy and joy that accompanies the midwife who works autonomously is balanced equally by the ever present possibilities for deep pain and loss. Inevitably this is part of the cycle of life.

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