AUTONOMOUS PRIVATE MIDWIFERY PRACTICE:
A RETROSPECTIVE 1994 – 2000

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"In the rich world the fate of real women is much like that of the ecosphere: the woman is considered by modern technology to be a case suitable for treatment. She is like a crop that could be improved, or a landscape that could be improved, or a river in need of damming. What we do know is that she cannot be left alone. She cannot simply grow into whatever it is she could be. She has to be modified.”
(Germaine Greer 1999)

SUMMARY

This paper provides an overview of an independent midwifery practice conducted in metropolitan Adelaide for the years 1994 – 2000. The solo caseload practice provides prenatal, intrapartum and postnatal services for approximately 24 – 30 families / year utilizing the 'relational emancipatory model of midwifery care' developed by the author. A distinguishing feature of this model is continuity of midwife carer throughout the childbearing continuum. Outcomes for 117 women and babies are presented. The relationship of isolation to private midwifery practice in Australia is considered, further developing the themes of personal, professional, structural and cultural challenges to autonomous practice. [These themes were initially introduced in a previous paper presented at The Autonomous Practice In Nursing And Midwifery Conference, Adelaide 1996 : Independence & Partnership] Retrospection that incorporates the political orientation of critical social theory and the process of reflexivity is utilized to illuminate the authors experience. Issues associated with implementing new models of midwifery practice in Australia are raised. In particular, consideration is given to incorporating the best aspects of autonomous midwifery to the community group practices envisioned for the future. Strategies to create publicly funded, sustainable models of community midwifery that balance continuity of carer, collegial support, employment flexibility and satisfaction, and provision of superior services and outcomes for mothers, babies and families are also considered.

Critical Social Theory And Reflexivity

Critical social theory seeks to make reality visible by examining the relationship between power and knowledge (Habermas 1971). A central idea is that ‘reality is constituted and mediated by language and texts’ which ‘are in turn constituted and mediated by the knowledge and power of certain influential groups in society’ (Cheek et al 1995, p.163). Dominant language and texts manifest as a discourse. Competing discourses are essentially competing claims to power, authority and influence (Foucault 1980). The underlying purpose of critical social theory is ‘enlightenment, empowerment and emancipation of individuals’ through transformation of the social order (Cheek et al 1995, p. 163). In critical social theory reflexivity is a process that involves consideration of ‘one’s own place in the social world …..as a consequence of one’s experience in the membership of social groups”
In the following paper the author’s position as woman, mother and independent midwife in Australian society at the beginning of the twenty-first century is considered in relation to competing discourses of gender, childbearing and motherhood.

**Discourse In Birth, Gender And Motherhood: The Retrospective Context**

‘Giving birth and being born’ is both initiation and transformation: powerful experiences that permeate all dimensions of being (Mauger 1996, p. 21–22). Universally, in all cultures and all classes, the birth giver is woman in woman’s body. The position of woman as embodied birth giver has been considered by many fictional and non-fictional texts over the past 30 years (Piercy 1976, Atwood 1985, Rich 1979, Daly 1978, Al-Hibri 1984, Raymond 1993, Wolf 1993, Greer 1999). All these commentators engage the issue of woman’s identity and place in society as having a strong relationship to woman’s ability to mediate her birth giving potential through her body. Some feminist authors have even claimed that women’s liberation will not be complete until technology has ‘freed’ the female body from its birth giving potential altogether (Firestone 1970). Because life is lived in a body, it has been asserted that no history of the body can be written without considering its location in a political field (Foucault 1980). For women individually and collectively this means that where childbirth and mothering are concerned, the personal will always be political. The author’s own journey as woman, mother and midwife is no exception.

That ‘consciousness’ and ‘mind’ are entities that inscribe and manifest themselves in and through the body, and in systems beyond that of the body, (eg: social, psychological, cultural and spiritual spheres), is not a new idea (Capra 1984). Inquiry in this area strongly suggests that wisdom manifests in patterns of relating and relationship (Buber 1970, Bugental 1976, Northrup 1998). These patterns of relating and relationship are the keys to transforming systems, structures, identities and bodies. Crouch & Manderson (1993) and Peterson (1996) demonstrate the particular significance of this in relation to childbearing, women’s self-esteem and family relationships.

At the Australian Homebirth Conference in Byron Bay last year, participants were reminded that ‘where there is continuing separation between women’s bodily experience and their mental experience, a society is well on the way toward madness’ (Greer 1999). These views provide an apt context for reflecting on the dominant interests associated with the accelerated medicalisation and increased morbidity associated with childbirth and motherhood in a modern, western industrial nation such as Australia at the end of the twentieth century (Willis 1989, Wagner 1994, Lane 1999). In her presentation Greer questioned whether womanhood will survive the twenty-first century. This is not a flippant speculation. Like others before her (Oakley 1984, Corea 1985, Rowland 1992, Raymond 1993) Greer gives real and current examples of how culture has ‘criminalized the uterine environment,’ and how pregnant and birthing women are ‘controlled, dominated and sexualized’ by unnecessary, expensive, and aggressively marketed medical technologies, whilst the social role of the mother continues to be deprived of any importance (Greer 1999).

Not only has the womb been ‘captured,’ so too has womans autonomy to self-determine her own childbearing script and to define and transform her own embodied and social identity. Western medical constructs of pregnancy, birth and motherhood as potential and actual pathology are reflected in current intervention statistics in Australia that are well outside the range recommended by the WHO (Roberts, Tracy & Peat 2000). Already they are fast tracking rich women to a futuristic techno-cyborg birth culture (Graham & Oakley 1981, Davis – Floyd 1994, Murphy – Lawless 2000). Similar trends however are evident in many women in poorer countries who are also being colonised with western medical technology (Wagner 1994). The obvious question is: where is the midwife, the traditional journeying companion of woman and her family throughout the childbearing continuum?
What Is A Midwife?

Historically midwives have been the custodians and facilitators of the physiologic birth process (Ehrenreich & English 1973). They have a role in enhancing the self confidence of women and their families throughout pregnancy, childbearing and early parenting, and to refer and support where there is deviation from the normal (Crebas 1989). Midwifery practice entails an ongoing relationship which has been described as the mediation between between nature and culture (Kitzinger 1991, p. 18), or more directly by Katz – Rothman (1990, p.170) as ‘feminist praxis’

Midwifery works with the labor of women to transform, to create the birth experience to meet the needs of women. It is a social, political activity, dialectically linking biology and society, the physical and social experience of motherhood.

The World Health Organisation (WHO 1996, p. 6) recognizes the midwife as the most appropriate and cost effective type of health care provider to be assigned to the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications.

Despite international definition of role and scope of practice of the midwife (endorsed by ICM, WHO and FIGO 1992), a decade of state, national and international government reports* calling for major reform of maternity services, and many independent studies** demonstrating superior outcomes when women undertake midwifery care, few women in Australia identify a midwife as their primary caregiver (Lane 1999, p. 6).

It is asserted that the status of midwifery has a relationship to the status of women within a community, state or country. The value and esteem in which women, children and families are held is directly related to the status of the midwife (Oakley & Houd 1990).

One must question the role, status, practice and perception of the midwife in Australia at the beginning of the twenty – first century. Is midwifery nearly extinct, merely invisible, or experiencing a professional, cultural and social identity crisis ................. ?

Overview Of An Independent Midwifery Practice

Recent scholarship serves as a powerful reminder that ‘midwifery practice is always a political act’ and that ‘what we name ourselves and our practice is of critical significance’ (White 1999, p. 9; Thomson 1996). My intent in educating myself as a midwife, was in order to practice midwifery. When I registered as a midwife in South Australia in 1993 I brought with me 9 years experience, socialisation and post - graduate education as a general and psychiatric nurse. It was as clear to me then as it is now that there were few places within mainstream maternity service provision to practice midwifery according to the International Definition of the Midwife, despite the funding and rhetoric of the federal, ‘Alternative Birthing Services Program.’ In 1993, organization of maternity services dictated that there were many offers of employment to practice maternity nursing under the title ‘midwifery.’

Given current and projected shortfall in the number of midwives in Australia, it is not cynical to expect this to continue, despite the implementation of new midwifery models.

* In the past 10 years women in Australia have repeatedly requested ‘safety, choice, continuity and control’ in maternity care via State & Territory Ministerial Reviews of Birthing Services, 1996

** Superior outcomes across a range of indicators are identified when women undertake continuity of midwifery care in both Australian and international studies (Waldenstrom & Turnbull 1998; Rowley et al 1995; Biro & Lunley 1991; Tyson 1991; Tew 1990; Damastra – Wijmenga 1981).
I commenced private midwifery practice in 1994, after establishing mentoring and preceptorship arrangements with several Independently Practising Midwives (IPMs) in Adelaide. These IPMs were experienced in providing woman-centred, continuity of midwifery care throughout pregnancy, birth and postnatally, all were accredited to the national standards of the Australian College of Midwives Inc (ACMI), and utilizing the full range of their skills. In 1995 I gave birth, at home, to my daughter, and must strongly acknowledge the personally transformative nature of this experience in contributing to my own development as woman, midwife and mother. By 1997 I was myself able to accredit with the ACMI as an independently practising midwife and the same year successfully applied for clinical privileges/admitting rights to two public birthing units attached to tertiary referral maternity hospitals in Adelaide.

Since 1994 continuity of midwifery care throughout antenatal, intrapartum and postnatal phases has been provided for approximately 130 women and their families. Place of birth has included hospital, birthing units, and homebirth, with the majority of care provided in people's own homes. Independence does not mean isolation, and collaboration with obstetric colleagues, other health professionals, and community networks is a regular occurrence to optimise health outcomes for families.

On average I attend 2 births/month, in addition to ongoing antenatal and postnatal consultations. In terms of caseload practice this is considered the equivalent of .5 FTE, but depending upon needs, outcomes and actual labour and birth times, this can fluctuate. (In the case of homebirth a second midwife will also attend for support). I appreciate the flexibility of caseload practice as during this period I have supplemented my income in several ways, including midwifery relief work, consultancy, and the facilitation of “From Pregnancy To Parenting” groups which I coordinate in conjunction with a local yoga centre and naturopath.

Independent midwives contract with families on a private ‘fee for service’ basis, as there is no public health reimbursement/medicare access to rebate midwifery service in Australia. Some private funds such as Health Partners, NIB, and Defence Health are providing full rebate toward the cost of homebirth, but the large providers such as Medibank Private and Mutual Community exclude midwifery from reimbursement status. Current approximate cost of continuity of midwife care for pregnancy, birth and postnatal visiting is $1500 - $1700. The ‘fee for service’ arrangements in private midwifery practice raise important issues of access and equity, creating tensions that this author has found ethically confronting at the level of the personal and the professional. Where women and their families have paid for my services over the past six years I estimate that they have saved the public health system over 250,000 dollars, (a conservative estimate and far in excess of my own remuneration).

It is often assumed that independent midwives only provide care for ‘low risk,’ affluent, middle class families. In my experience the profile of families seeking continuity of midwifery care is rather more diverse. Increasingly I am approached by families with ‘special needs,’ or those whose pregnancies have been labelled ‘high risk’ for continuity of midwifery care, as collaborative support to their obstetric care. Some of the issues confronting families I have provided care for over the last twelve months have included obstetric cholestasis, preexisting mental health problems, infant adoption, substance abuse, childhood sexual abuse, stillbirth, recurring infant losses due to genetic degenerative condition, infant hydrocephaly, and genetic termination. If ‘low risk’ women require continuity of midwife care to keep birth ‘safe’ and ‘intervention free,’ ‘high risk’ women and those with ‘special needs’ require it even more to support them through experiences of intervention, unexpected outcomes, and to adapt to challenging new identities, relationships and circumstance.

* Formal recognition of these arrangements is now provided via Guidelines For The Granting Of Clinical Privileges And Admitting Privileges For Nurses And Midwives In Public Hospitals In South Australia (July 1999) - Department of Human Services SA.
The Relational Emancipatory Model Of Midwifery Care

Independent midwifery in Australia has sought to distinguish itself from midwifery practised by employees of the state, and also from midwifery practised by those tenured to private service contracts in hospitals or with other providers. 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. This allegiance is the foundation of a relationship whose boundaries are mediated by cornerstones of responsible self - determination and professional, personalised continuity of midwife carer. The ‘relational emancipatory model of midwifery care’ (Donnellan – Fernandez 1993) engages the midwife as a multidimensional facilitator of passage throughout the childbearing continuum. It is acknowledged that this process is dynamic and that the source and potential for transformational reciprocity resides within all who are engaged in the relationship.

Continuity of Midwife Carer : Maternal & Infant Outcomes In 117 Families

Obstetric intervention and morbidity are significantly reduced where continuity of midwife carer is practiced in conjunction with appropriate referral.

# Total continuity of midwife care for 111 cases : 86 planned homebirths
25 planned hospital or birthing unit births
46% having a first baby

90% Spontaneous vaginal birth rate (includes 5 home VBACs & 1 birthing unit VBAC)

7% Caesarean section rate
3% Assisted vaginal birth rate (1 forcep liftout, 1 ventouse/maternity exhaustion, 1 ventouse/second twin)

30 Waterbirhths (3 of these in hospital)

Perineal Outcomes:

64% Intact
15% First Degree Tear
20% Second Degree Tear
1% Episiotomy

Transfer rate from planned homebirth to hospital is 10%.

Note: There were 6 antenatal referrals / transfers to specialist obstetric care
These included: # Preeclampsia @ 33 weeks
# Antepartum haemorrhage @ 37 weeks
# Breech presentations x 2 @ 36 weeks
# Obstetric cholestasis @ 24 weeks
# Fetal supraventricular tachycardia @ 33 weeks

96% of infants fully breastfeeding at 4 months postpartum
4 Cases of postnatal depression within 6 weeks postpartum with psychiatrist involvement
0 Neonatal or maternal deaths

The above outcomes compare favourably with physiological indicators collected by the Pregnancy Outcome Unit of the South Australian Health Commission for 1998.

* Satisfaction levels with care throughout antenatal, intrapartum and postpartum phases was high as evidenced by comments returned with 6 week postpartum formal evaluation.

* Birth Outcomes in South Australia 1998: 62% spontaneous vaginal birth rate;
27% induction rate; 23% augmentation rate; 31% epidural rate;
24% caesarean section rate (SAHC Pregnancy Outcome Unit)
CHALLENGES OF ISOLATION IN INDEPENDENT MIDWIFERY PRACTICE

Independent midwifery practice occupies a position very much on the margins or fringe of maternity service provision in Australia. It could hardly be described as an accessible 'option,' or even an equitable 'choice' for the majority of the population, given that many do not even know what a midwife is, let alone how to access such a service, even if one could afford to pay for it. Despite its position, independent midwifery currently offers some midwives and families a woman-focused paradigm as an alternative to 'medically managed childbirth,' which continues to dominate mainstream services and to demonstrate unjustifiable rates of intervention and cost (Lane 1999, Roberts et al 2000).

Cultural Challenge

One of midwifery's biggest challenges in the twenty-first century in Australia is a strong public relations exercise; ie: midwifery must promote itself back into the community where for women it is most usefully located, but has long been forgotten (Summers 1996, Green 1999). Childbearing and rearing as a social experience also requires reclamation by women's and midwives groups working in partnership to identify common values, goals and directions, eg: Victorian Midwifery Campaign 1999.

The entrenched effects of a century of institutionalised birthing practice have shaped several generations of public perception (Willis 1989). Many women experiencing normal pregnancy and birth in this country now believe that it is not only desirable, but essential to have a specialist doctor / obstetrician 'manage' their pregnancy and birth. Women have been enculturated with illusions of greater safety, control, and the elimination of pain in childbirth via images projected by those with power to influence the mediums of popular culture, but without any of the responsibilities to advise on the physical, personal and social costs associated with such 'choices.' Midwives working within institutionalised settings are identified and perceived as 'nurse,' (and therefore implicitly subject to the direction of a doctor), including when they provide most of a woman's pre or post birth care, or are the principle attendant at a birth.

That women as a group are still seeking diversity of care options in childbirth has been extensively documented in Australia over the past decade, (NHMRC 1996, Federal Senate Inquiry 1999). Midwives can provide them with viable options that are safe, satisfying and cost effective, if these options are a visible part of mainstream culture. It is certainly in the public interest to understand what a midwife is, and what they do. On a small scale independent midwives have promoted the visibility of midwifery in their local communities, and to date have also provided examples of alternative midwifery practice models in action. Additionally, they have often led the way in fostering networks with women's groups in the community (Lecky - Thompson 1996).

Structural Challenge

Structural isolation entails some of the most formidable barriers and challenges to those wishing to practice autonomous midwifery, and to those wishing to access the services of independent midwifery. Structural 'gatekeeping' is the mechanism by which current medical monopoly over childbirthing services is maintained, further aiding and abetting dominant medical hegemony within broader culture. By structural isolation this author refers to funding arrangements, legislative arrangements, professional indemnity arrangements, and access arrangements (to essential services such as diagnostic screening, pharmacological substances, hospital admission, integrated specialist medical service / advice), which perpetuate the status quo.
At a material and practical level structure dictates the form and accessibility a population has to services. National reform to the organization and funding of maternity services is urgently required if real options and sustainable mainstream change are to occur.

(Donnellan – Fernandez 1996, 64)

Current mainstream service provision literally, bureaucratically and financially dissects women’s experience and body into discrete and fragmented episodes of ‘care,’ typical of western medical systems based on illness models. Midwives and citizens are justified in claiming that present public and private funding mechanisms that do not provide reimbursement for midwifery services privilege medical dominance and comprise anti-competitive behaviour (NSW Midwives Association Inc 1999; ASIM 1999). Multiple claims to this effect before the Australian Competition And Consumer Commission (ACCC) would challenge the legitimacy of discrimination inherent in current funding arrangements. These constitute little more than ‘protectionism’ for medical industry and its affiliated ‘products.’

Rather than continuing to prop up an ailing private health insurance industry at the expense of Medicare and public health interests, the federal government needs to introduce a new and separate maternity funding mechanism that is equitable and accessible to all Australian families. A maternity funding mechanism that levels the field for all providers, including midwives, has been implemented in New Zealand via adoption of a transparent, uniform maternity benefits schedule. In the eight years since its introduction 60% of women in NZ now identify a midwife as their lead maternity carer and 80% of labouring women know their midwife (Guilliland 1999, Cleal 2000). One may ask where is the economic prudence, common sense and interests of the state that denies its citizens and families access to the safest, most cost effective birth care recognized by the WHO. It is obvious that it is not ‘with’ or ‘for’ women, children and families.

Whilst accessible indemnity arrangements for midwives are now available they are certainly not ‘subsidised’ by the state as they are for some doctors. And whilst documents and process such as ‘Review of services offered by midwives’ (NHMRC 1998) and Guidelines For The Granting Of Clinical Privileges And Admitting Privileges For Nurses And Midwives In Public Hospitals In South Australia (DHS SA 1999) move midwives toward greater possibilities for autonomy, they are by no means uniform or uniformly administered in all states and territories of Australia, nor are they static and without challenge. Despite all this, trends in Australia toward deregulation and the outsourcing of public service contracts herald the potential for whole new sets of arrangements in the future, particularly innovative, cost effective models of midwifery care, more particularly so if they are lobbied for by the community.

Professional Challenge

Professional heresy appears to be the new charge against those who question Australian midwifery’s present educational and legislative status as ‘specialist nursing practice’ (White 1999). Whilst 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 (Donnellan – Fernandez 1996), recent resistance to public and professional demand for change has been articulated by powerful nursing organizations such as the Australian Nursing Federation (Iliffe 2000). Another view is 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 at local, national and international levels well into the twenty first century.

(Donnellan – Fernandez 1996, 65)
After the author first registered as a midwife in Australia, it took a further 4 years to achieve adequate theoretical and clinical preparation to apply for Independent Midwife Practice accreditation with the Australian College of Midwives Inc. The current realities and need to address adequate educational preparation for midwives in Australia has recently been examined by Leap (1999) and ACMI Victorian Branch (1998).

Issues of education and regulation are fundamentally linked. When the author received her Independent Midwife accreditation parchment from national ACMI in 1997, it was numbered 88. The assumption was that there were 88 independently practising midwives (IPM’s) in Australia who were accredited to ACMI standards. In reality though, the number of practising IPM’s is probably four or five times this. The truth is, nobody, including the regulatory authorities, have any idea ....... Nor is there an accurate national picture of the skill sets maintained by midwives in institutional settings. This makes labour force planning little more than haphazard guesswork, and therefore a serious concern.

Current arrangements to regulate midwives under state and territory Nurses Acts are no longer appropriate. Apart from their inconsistencies (Bogossian 1998), they are simply not keeping pace with contemporary public health care, nor the education and practice realities of midwifery (AMALG 1999). They provide no assurance or evidence to the public or profession that rigorous standards or guidelines for practice are being met, nor that any quality assurance monitoring is occurring. The assertion that Nurse Practitioner legislation is ‘a good thin – edged wedge’ (White 1999) is refuted on the basis that the title and skill sets of a ‘nurse practitioner’ do not equate with the title and skill sets of a ‘midwife,’ no matter how attractive the package looks. Nurse practitioners practise nursing and midwives should be practising midwifery. That nurse practitioners are legislated to practise nursing is appropriate. That midwives are legislated to practise nursing is one of the fundamental problems with maternity care in Australia today.

Summers (1995) analysis of the demise of the community midwife in South Australia provides a salutary history lesson on the power and abuses of regulation to control and exclude. Barclay (1993) and Lecky – Thompson (1996) have identified regulatory ‘domination’ and ‘antagonism’ toward midwifery ‘by a nursing profession larger in numbers and power structures, that denies the right of midwives to a separate professional identity’ (Lecky – Thompson 1996). However, current projects and groups offer future hope of resolution to longstanding professional issues of midwifery subsumation within nursing in Australia (eg: National Code of Practice for Midwives [ACMI] Australian Midwifery Action Project [AMAP], Bachelor of Midwifery National Taskforce and Australian Midwives Act Lobby Group[AMALG]).

A strong global trend away from requiring all midwives to first be educated as nurses is continuing and many countries have already legislated for specific midwifery regulation, (eg: United Kingdom, Canada, New York State, Phillipines, approximately half the states of North America). AMALG (1999) is a joint consumer/midwife collective working in partnership in Australia to provide advocacy for midwifery legislation based on the international definition, role and scope of practice of the midwife that is consistent between all Australian states and territories.

Professional heresy among midwives and consumers is gathering momentum in this country. Heresy comes from ‘hairesithai’: to choose; and heretic from ‘heretique’: her / etiquette? (Daly 1978). Midwifery autonomy in Australia will not be determined by midwives alone. The collective will of women and midwives working together will more effectively shape any profession that defines itself through those it serves. The current challenge for all midwives is to choose where they stand and to make it explicit.
Personal Challenge

A criticism often levelled at independent midwives is that they practice in isolation. Interestingly such aspersions are never cast on other health professionals working in private practice. Whilst the potential to become insular exists in any solo practice, independent midwives more than most recognize the importance of maintaining supportive professional and peer networks. Working in a metropolitan area enables an IPM easier access to integrated services such as community resources, the support of midwifery colleagues and professional organizations, and specialist obstetric and paediatric services. These supports are reassuring, and with the use of modern technology may now be more accessible to rural midwives also.

Personal reward in autonomous midwifery practice comes from job satisfaction through the opportunity to participate in transformative relationships that facilitate positive growth for women, midwives and families. These relationships of reciprocity have informed the author’s own childbearing and parenting experience by making visible the multidimensional links between power and knowledge at the level of the body, the intellect, the emotions, and the social, cultural and spiritual contexts. This process has therefore also contributed to the author’s development of theory and praxis in midwifery.

A benefit of self-employment is control over the level of one’s caseload. Flexibility of appointment times can also mean that independent practice is compatible with family and supplementary work commitments. The costs to one’s lifestyle however may be too high for some. One of the greatest challenges to commencing a solo midwifery practice comprises the insecurity and irregularity of income associated with operating a small business. Additionally, the physical, mental and emotional demands of carrying responsibility for a caseload can be burdensome and self-limiting when one is the sole midwife perpetually on call.

In recent times the high personal and professional costs associated with litigation and public scrutiny of practice have been experienced by Lecky – Thompson (1996; 2000). Midwives who practice independently are acutely aware of their ongoing vulnerability and exposure in systems currently challenged by their presence and practice.

SUSTAINABLE MODELS OF COMMUNITY MIDWIFERY

Since the introduction of the last national women’s health policy in Australia (Office For The Status Of Women 1993) there has been much interest and some evidence to demonstrate the implementation of maternity care that is more woman-centred, with increased continuity and greater midwife-led care. 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 (New Models Of Maternity Service Provision: Australian Midwifery Perspectives Conference 1998). The changes however are modest when one considers and compares the state of midwifery in England and New Zealand, both having experienced women’s demands for reform to maternity services over the past decade (Changing Childbirth 1993; Guilliland 1999).

In Australia as in England many continuity of care schemes have not progressed beyond the pilot stage. Many that have are severely modified from the original vision of knowing the midwife who will birth with you and have been restricted to limited groups of women, defined by parameters such as geographic location, risk status, and socio-economic factors. Overall in both countries, obstetric intervention rates are rising and midwife labourforce shortages are increasing (Anderson 2000). Despite this, personal and cultural conflict between the forces of globalization and local identity, coupled with government pressure to downsize and streamline services (Friedman 1999) makes the current economic climate an opportune one for introducing cost-effective innovations in public health care in Australia.
Women and midwives need to seize this opportunity. They need to collaborate locally, regionally and nationally, and to exert their collective will in the political arena to make the changes happen. Community midwifery is the chosen course because its underlying philosophy is a social model of birth that is woman-centred, its location is firmly in the places where families live and work (therefore local networks and support structures can be accessed and extended in a true primary health framework), and it is publicly funded.

In Australia the principle challenge to widespread introduction of community midwifery models include the absence of a recent culture or history of community midwifery, and entrenched funding, education and service delivery based on medicalised/institutionalised models of birth. One of the more obvious reasons that team midwifery has been embraced by hospitals in England (and now Australia), is that it maintains institutional control over women via control of government funding and therefore control of birthing services; (ie: the interests of institutionalised birthing are preserved with the illusion of greater benefits for women). Tactics that preserve current arrangements in the organization of mainstream birthing services have already been utilised to stall change via the 'so-called Laura Ashley flowered curtain approach' (Murphy-Lawless 2000, p 343), more widely recognised as, 'the birthing centre.' It is not surprising that many private hospitals with outrageous rates of intervention now also advertise their 'birthing centres.'

Team midwifery does not provide continuity of carer, (in fact the larger the team, the more fragmented the care). Research has identified that caseload midwifery provides greater continuity of care and increased satisfaction for women and midwives (Prider 1997). Team midwifery means that the labour of the midwife can be preserved for use by the institution, and those whose interests it serves. Caseload midwifery means that the labour of the midwife can be preserved for use by whom, it is meant to serve. Cronk & Flint (1989), SELMGP (1993), Page (1995) and Prider (1997), have all documented successful examples of community midwifery in action, including some of the pitfalls. Community midwifery for this author involves blending the principles of continuity of midwife carer/caseload practice with the structural, functional, and peer support of small groups of midwives (6–8) working in dynamic partnerships, from a variety of centres in local communities. The South East London Midwifery Group Practice (SELMGP 1993) provided a good example of this style of community midwifery practice.

**Principles Identified As Integral To Success**

'Willing participants' are essential if community midwifery is to be successfully implemented and sustained. Common vision and commitment from midwives, community and government is required at the outset. This entails community consultation, development of collaborative networks, funding commitment, and effective communication/interface between midwives and other health professionals. Initial promotion and marketing of community midwifery services and their benefits to the community is vital, as is the need for ongoing evaluation. At a practical level, midwives need to have control over their own workloads. (Caseloads of 35–40 women annually have previously been identified as a reasonable primary caseload for one midwife FTE) Appropriate industrial negotiation around salary packaging and adequate leave entitlement is also important. Within the practice, team building exercises are necessary to establish good working relationships and regular meetings fulfil needs for ongoing support, conflict resolution, goal setting and review of objectives. Managers are required to support the midwives and an experienced group leader is essential to facilitate skill and confidence building in new members, and ensure adequate peer review.

Greer (1999) asserts that 'Woman's desire for autonomy extends into every aspect of her life.' That women may stand in their place of power in Australia requires the exercise of collective will by women and midwives working together to achieve the change that neither can bring about alone.
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