LEARNING OUTCOMES

After studying this chapter, you should be able to:

1.1 identify your personal philosophy of midwifery
1.2 outline the role and scope of practice of the midwife
1.3 understand the complexities of midwifery education
1.4 examine how midwifery, as a profession, is regulated in Australia and New Zealand
1.5 identify the personal qualities of the midwife
1.6 understand the demands of working within the midwifery profession.
Introduction

Midwifery is a dynamic profession that is responsive to change. In recent years, social, economic and technological forces have altered the context of midwifery significantly. The scale of healthcare provision has changed greatly; philosophies and values have been adjusted and the restructuring of healthcare provision has been dramatic. There have been government and independent reviews of maternity services and changes to midwifery education and the accreditation of programs of study. In Australia, the latest of these was the publication of the National Maternity Services Plan (AHMAC 2011), which presented a five-year vision for maternity care in Australia. Its vision included the following:

...women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. (AHMAC 2011, p. iii).

It is clear from this vision that there are many concepts that need to be considered and implemented. Public expectations regarding involvement in care and opportunities for informed choice have increased, and in many cases women and their families are seeking different models of maternity care where they can work in partnership with their care providers. The partnership model of care has been in existence in New Zealand since 1996 when midwives were autonomous practitioners with full prescribing rights, with the ability to make referrals, order diagnostic tests and access hospital facilities and government fee-for-services (Guilliland & Tracy 2015).

This chapter will provide an introduction to the midwife, midwifery education, models of midwifery care, professional regulation and registration, professional organisations and personal qualities, which will help students with their midwifery education and role as a qualified health practitioner.
1.1 Midwifery philosophy

LEARNING OUTCOME 1.1 Identify your personal philosophy of midwifery.

The International Confederation of Midwives (ICM) has a philosophy of midwifery care that states that pregnancy and child-bearing are usually normal physiological processes that are profound experiences with significant meaning for the woman and her family. It maintains that midwives are the most appropriate care providers to attend to the woman offering care that promotes, protects and supports the woman, while recognising ethnic and cultural diversity. Midwifery care is holistic and continuous and takes place in partnership with the woman. It is ethical and competent, and informed by education and application of evidence (ICM 2014). Midwives provide high-quality professional care to women and their families, and are autonomous, accountable and responsible within their scope of practice.

ACTIVITY 1.1

Write a short statement about your philosophy of midwifery and why you want to become a midwife. Your statement should centre on your beliefs, concepts or ideas, and your attitude. This statement can be written without any reading. It should focus on why you want to be a midwife and what you believe. When you have written this statement, put it somewhere safe so that you can revisit it after each semester of study and reflect on where you are in your midwifery journey. If you are experiencing difficult times within your program, refer to this statement of your philosophy. You may also want to develop your own midwifery mandala. A mandala is a circle that can help to focus your philosophy in a visual way, i.e. where are you in the circle, where are the women and families, where are the other health practitioners and the support people who will be helping you on your journey to become a midwife.

1.2 The midwife

LEARNING OUTCOME 1.2 Outline the role and scope of practice of the midwife.

The word ‘midwife’ is mentioned in the Bible in Genesis where it is stated:

The time came for Rachel to have her baby, and she was having difficult labour. When her pains were at their worst, the midwife said to her, ‘Don’t be afraid Rachel; it’s another boy’ (Genesis 35:16–17).

Midwifery, then, can be seen as a very old profession. In the past, the midwife would have been an autonomous practitioner, with or without education, and getting on with the job of assisting women. Now, the midwife is a professional, educated person able to provide competent and safe practice at all times. However, historically, midwifery, and consequently the midwife, had been subordinated by nursing and medicine. Fahy (2007, p. 2) provides a historical analysis of the professionalisation of medicine from the nineteenth to twentieth century when it was ‘inextricably linked to an obedient nursing profession which in turn was the key player in the eradication of midwifery as an independent occupational group’.

To be a midwife is to understand the role, responsibilities and scope of practice of being a midwife. The midwifery profession is recognised globally and is defined by the ICM (2011) as:

a person who has successfully completed a midwifery education program that is duly recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

This definition is complex as it includes areas such as education, regulation and practice. The professional status and regulation of midwifery nationally and internationally is complex and varies in different countries. Midwives in rural Cambodia practise differently to midwives in urban cities and tertiary health centres. While we should recognise these differences, there is still an underpinning scope of practice that all midwives should adhere to.
ICM scope of practice

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units (Revised and adopted by ICM 2011. Due for review in 2017).

Midwifery, as a profession, is recognised globally, although there are wide variations in education and scope of practice between countries. What is evident from the ICM scope of practice is that the midwife works in partnership with women to provide support, care and advice during pregnancy, labour and the postpartum period (Glover 2016). While midwives can provide independent care, they also have a legal obligation to work with other health professionals. Midwives work in all kinds of settings which can include hospitals (public and private), homes, community, clinics, rural and remote areas, and private midwifery services such as My Midwives. The practice of the midwife will be specific to the context of where the care is being provided.

The professional status of midwifery began with the Midwives Act 1904 in New Zealand and a Midwives Registration Bill in 1915 in Australia. Prior to 2010, each Australian state and territory had its own Nurses Board. Today, midwifery practice in Australia and New Zealand is governed by the Nursing and Midwifery Board of Australia (NMBA) and the Midwifery Council of New Zealand respectively. Both of these organisations have developed codes of practice and ethics that give clear guidelines for midwifery practice. Midwives have a legal obligation to ensure that they practise within professional and personal boundaries, and as they begin to work with women in the partnership model, they will need to know where the boundaries of their relationships begin and end. This also applies when working with other health practitioners.
1.3 Midwifery education

LEARNING OUTCOME 1.3 Understand the complexities of midwifery education.

Midwifery education in Australia was a state/territory responsibility until 2009 when the Australian Nursing and Midwifery Accreditation Council (ANMAC) was established to provide midwifery education providers with a set of standards for midwifery programs. Prior to this, midwifery education was offered by public hospitals that provided maternity care. Students were already registered as nurses and midwifery was seen as a second certificate. In the 1980s nursing began to transfer its training from the hospital-based apprentice system to the tertiary setting and transferred fully to the university sector by 1993. At this stage, midwifery stayed in the hospital system as it was not seen as a profession in its own right, but rather a specialty of nursing. There were postgraduate degrees offered but these were neither prolific nor were they well subscribed, as they were expensive to undertake.

There are now three main education pathways in the higher education sector for midwifery: the three-year Bachelor of Midwifery; a post-registration Bachelor of Midwifery, where the student is already a registered nurse (the student can wait between degrees or they can enrol in a double degree and graduate with a Bachelor of Nursing/Bachelor of Midwifery); or a postgraduate qualification such as a graduate diploma or master’s degree, if the student is already registered as a nurse. The length of these programs varies; however, they are all more than one year as students have to meet the strict accreditation requirements mandated by ANMAC. These include mandatory practice experiences in which the students must meet the requirements of continuity of care experiences; antenatal, labour and birth care; and postnatal and neonatal care.
In New Zealand, pre-registration midwifery education has been offered as a three-year Bachelor of Midwifery since 1992. All programs in New Zealand are subject to approval by the Midwifery Council of New Zealand and students must meet the competencies for registration as a midwife. Students graduate as autonomous practitioners able to practise across the scope of midwifery (Gilkison et al. 2016). Their Australian counterparts have to complete a one-year Transition to Professional Practice Program (TPPP) upon completion of their studies.

Midwifery education is underpinned by standards, guides, codes and competencies (see figure 1.1). By accepting and implementing these documents, it is clear that midwifery education (and ultimately regulation) is becoming more universal. This control will assist education providers in preparing the global midwife for the future.

<table>
<thead>
<tr>
<th>FIGURE 1.1</th>
<th>Australian national midwifery education and practice standards, guidelines, codes and competencies</th>
</tr>
</thead>
</table>
| **Accreditation standards**  
- National Guidelines for the Accreditation of Nursing and Midwifery Programs Leading to Registration or Endorsement in Australia (ANMAC 2015)  
- Midwife Accreditation Standards 2014 (ANMAC 2014)  
- Programs Leading to Endorsement for Scheduled Medicines for Midwives Accreditation Standards (ANMAC 2015)  

**Codes: ethics and professional conduct**  
- The Code of Ethics for Midwives in Australia (NMBA 2008)  
- The Code of Professional Conduct for Midwives in Australia (NMBA 2008)  

**Competency standards**  
- National Competency Standards for the Midwife (NMBA 2006; under review)  

**Decision making frameworks**  
- Midwifery Practice Decisions Summary Guide (NMBA 2010)  
- Midwifery Practice Decision Flowchart (NMBA 2013)  
- Safety and Quality Framework for Privately Practising Midwives Attending Homebirths (NMBA 2010)  

**Professional boundaries**  

**Professional practice guidelines**  
- National Midwifery Guidelines for Consultation and Referral 3rd edn (ACM 2013)  
- Guidelines for Professional Indemnity Insurance Arrangements for Midwives (NMBA 2012)  
- Guidelines for Advertising Regulated Health Services (AHPRA 2014)  
- Nursing and Midwifery Guidelines for Mandatory Notifications (AHPRA 2014)  

**Registration standards**  
- Registration Standard Continuing Professional Development (NMBA 2016)  
- Registration Standard Criminal History (NMBA 2015)  
- Registration Standard English Language Skills (NMBA 2015)  
- Registration Standard Professional Indemnity Insurance Arrangements (NMBA 2016)  
- Registration Standard Recency of Practice (NMBA 2016)  
- Registration Standard for Endorsement for Scheduled Medicines for Midwives (NMBA 2017)  
- Eligible Midwives Registration Standard (NMBA 2010)  

*Source: ACM, AHPRA, ANMAC, NMBA. Adapted from Pairman & Donnellan-Fernandez 2015.*

Midwifery education is a shared responsibility between the higher education sector and the clinical venues where students undergo their midwifery practice experience. It is important that these partners work together to ensure students are able to complete their clinical requirements. Most programs of study...
have a 50:50 distribution of theory and clinical placement. These hours are suggested by the higher education sector; however, there needs to be enough time for the student to meet the clinical requirements. A conceptual framework and underlying philosophy should be evident in all courses. There should be evidence of a woman-centred approach to midwifery along with a continuity of care model. Primary health-care principles should also underpin the curriculum, and the curriculum should prepare graduates to be able to work to the full scope of practice as a midwife. Billett and Henderson (2011) suggest that any curriculum that is developed should promote professional learning, and integrate theory and practice. Students need to be self-directed in their learning and able to reflect on their practice. Most curricula have integrated the concepts of the biophysical and social sciences, and there is an ideation that evidence-based practice is integrated into all teaching. Cultural respect and safety are included in curricula with reference to Aboriginal and Torres Strait Islander peoples in Australia and Maori people in New Zealand.

**Continuity of care experiences**

An exciting component of the midwifery curriculum is the need for students to undertake a required and mandated number of **continuity of care experiences (COCE)**. COCE provide midwifery students with the opportunity to ‘establish, maintain and conclude a professional relationship while experiencing continuity with individual women through pregnancy, labour and birth, and the postnatal period regardless of model of care’ (ANMAC 2014, p. 24). This is a student-centred activity in that the student needs to identify women to recruit for this experience and manage the workload that the experience entails, while under the direct supervision of a midwife. The COCE is a core component of the curriculum. Sweet and Glover (2011, p. 85) identified three purposes for this workplace-based experience: students will engage with and reflect on the world of midwifery work; they will understand and develop their individual capacity for the profession; and they will understand the nuances of the many and diverse instances of midwifery practices and birthing women’s trajectories. While the COCE is done in the students’ own time, they will have the opportunity to develop an awareness of the role of the midwife and their own midwifery identity, and change their language from lay to professional.

**ACTIVITY 1.3**

1. Create a table and make notes about the following.
   - How will you develop your awareness of the role of the midwife?
   - How will you recognise your own midwifery identity? Does it relate in any way to your personal philosophy previously identified?
   - How will you recognise the change in your language from lay to professional. Here are a few examples:
     - the water broke (lay language)
     - the water was green (lay language)
     - the baby is flat (lay language that can be very scary as the mother believes her baby is flat)
     - lost her first baby (lay language) (Glover & Sweet 2016).

2. Read the following quote from Michel Odent, a famous French obstetrician, and consider the effect of language in a childbirth context.

   So many words commonly used to describe childbirth — support, patient, management, delivered by, coached, helped, guided — suggest that a woman does not have the power to give birth without being dependent on somebody else. This isn’t the case at all.

**Midwifery knowledge**

There are three kinds of knowledge gained through COCE and midwifery practice placements: conceptual knowledge, procedural knowledge and dispositional knowledge. **Conceptual knowledge** is the
‘development of facts, information, propositions, assertions, and concepts for practice and is developed over time from integration between theory and practice’ (Sweet & Glover 2011, p. 88). This knowledge can start off as basic and increase in complexity to a more sophisticated and deeper level. A student may start off knowing there is a clamp for the baby’s umbilical cord when it is born and then learn it is a Black’s clamp. The COCE assists students to develop this level of sophistication as they work in a triad situation with the woman, the midwife (or other health professional) and themselves. This is the ‘knowing about’ midwifery. The student will then reflect on these experiences to identify what they have learned from the COCE.

As midwifery is a practice-based profession, there needs to be the development of skills for safe practice. This is procedural knowledge and demonstrates the ‘knowing how’ to be a midwife (Sweet & Glover 2011). Midwifery students may undertake skills development in a simulated practice setting at university and then apply these skills in a real-life situation. The research conducted by Sweet and Glover (2011) found that midwifery students enjoyed task learning, but were also open to opportunistic learning when unplanned situations arose. When midwifery students embrace all learning opportunities, their confidence grows and they are able to reflect on their experiences.

The final knowledge is dispositional knowledge. This knowledge relates to the values and attitudes required to ‘be a midwife’ (Sweet & Glover 2011). It is through observing other midwives and their practice that midwifery students can identify how they want to be as a midwife. Developing awareness of the midwife role will begin as soon as the student commences the course of study. The midwifery student will identify good and bad role models, while developing their sense of agency and becoming an agentic learner. What this means is that the midwifery student will be an active, directive and intentional learner (Billett 2011). The student is the learner and the teachers, both in the university and clinical setting, support their learning and guide the student in active engagement. Sweet and Glover (2011) describe ‘hot learning’ which occurs when the student gets the opportunity for an unplanned learning experience, such as a rapid birth. The student can then reflect on the experience in collaboration with the midwife and the woman. ‘Cold learning’ occurs when the student is guided through debriefing and critical reflection on the same experience.

The midwifery student must be prepared before, during and after the COCE and the midwifery placement experience. This responsibility belongs with the university teacher, clinical teacher/facilitator, midwife/mentor and student (see table 1.1). The woman will also become a partner in these experiences.

<table>
<thead>
<tr>
<th>TABLE 1.1 Learning responsibilities prior to, during and after the COCE and midwifery practice experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teacher</strong></td>
</tr>
<tr>
<td>Prepare student for concepts, practice and language they may encounter in their initial experience.</td>
</tr>
<tr>
<td>Roleplay some anticipated experiences in the classroom. This could be as simple as taking an antenatal history.</td>
</tr>
<tr>
<td>Develop a level of proficiency in some basic skills such as taking blood pressure and listening to a fetal heart.</td>
</tr>
<tr>
<td>Discuss the reality of midwifery work, e.g. a labour can be considered normal one minute and an emergency the next, or a fetal heart may be heard and then not heard an hour later.</td>
</tr>
<tr>
<td>Prepare the student for reflection in and on practice.</td>
</tr>
<tr>
<td><strong>Student</strong></td>
</tr>
<tr>
<td>Know their professional and personal boundaries.</td>
</tr>
<tr>
<td>Identify learning objectives.</td>
</tr>
<tr>
<td>Know the requirements for their midwifery practice portfolio.</td>
</tr>
</tbody>
</table>

1This title has adopted the accepted medical spelling of ‘fetus’, rather than the common usage spelling of ‘foetus’.
To be a midwife

Teacher

During the COCE or midwifery placement experience

• Liaise with the clinical facilitators to ensure student is competent.

After the COCE or midwifery practice experience

• Teach staff to facilitate discussion with students to tell their ‘stories’ to their peers.
• Facilitate reflection on action.

Student

• Identify the midwife who will support their learning.
• Have some knowledge of strategies to negotiate new and first experiences.
• Know how to identify and seize opportunities for learning when the student has not learned the theory.
• Continue to identify own learning.
• Reflect in and on practice.
• Seek feedback from the clinical teacher/facilitator/midwife/mentor.
• Become part of the workplace and the culture (make sure it is a positive culture).

• Identify their learning.
• Complete all documentation of experiences.

Source: Sweet & Glover 2011, pp. 96–9.

Midwifery practice portfolio

Students are required to keep a record of their minimum mandatory practice requirements as specified by ANMAC or the Midwifery Council of New Zealand. Practice requirements in Australia include 10 COCE, attendance at 100 episodes of antenatal and postnatal care, and being the primary accoucher for 30 women. New Zealand students have similar requirements. A student’s portfolio is the evidence that will need to be presented at the end of the study program.

ACTIVITY 1.4

Do you know what an ‘accoucher’ is? If not, stop and find out. This is canonical knowledge, i.e. knowledge of your profession through language that is specific to your profession.

Models of care

There is a plethora of different models of care for women. Australian midwives work mainly in four models of midwifery care that were proposed by the National Maternity Services Plan (AHMAC 2011). Table 1.2 presents a brief overview of some of the models of care. Midwives work in areas such as antenatal care in clinics and doctors’ rooms, labour and birthing suites, delivery rooms, fertility clinics, postnatal wards and postnatal home-visiting services. They also work in urban, rural and remote settings.

In New Zealand, the model of care is a little different. Midwives work in a primary, secondary or tertiary setting; however, the model includes a lead maternity carer (LMC) selected by the woman to provide her care. This may be a midwife or a general practitioner who has completed a Diploma of Obstetrics and Gynaecology. The LMC is responsible for all the care that is provided throughout the pregnancy up until six weeks postpartum. In New Zealand, women can choose to birth at home or at a birthing centre in a maternity hospital. The LMC model is described by the New Zealand College of
Midwives (NZCOM) (2016) as the cornerstone of maternity services, allowing the woman a seamless maternity experience which meets the woman’s needs. The LMC can access any services they require to assist with the care of the woman.

**TABLE 1.2 Models of midwifery care**

<table>
<thead>
<tr>
<th>Model of care</th>
<th>Provider</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>Obstetrician-led care</td>
<td>Private rooms for care and delivery in a private hospital</td>
</tr>
<tr>
<td></td>
<td>Midwives such as ‘My Midwives’</td>
<td>Private rooms</td>
</tr>
<tr>
<td>Combined</td>
<td>Variety of health professionals, e.g. obstetrician, general practitioner, midwife, and others</td>
<td>Variety of settings</td>
</tr>
<tr>
<td>Public hospital care</td>
<td>May include midwifery models of care, midwifery-led care, midwifery group practice; homebirthing may be offered as part of the service</td>
<td>Public hospital</td>
</tr>
</tbody>
</table>
| Independent       | Midwives: these midwives have different working provisions | Homebirth                                               

**Navigating the midwifery practice experience**

The midwifery practice experiences of students will be identified by the university in collaboration with clinical venues in the area. It is usual for students to have some input as they may request to have an experience in a rural or remote area. Figure 1.2 provides some tips on how to ensure a successful midwifery practice experience.

**FIGURE 1.2 Tips for a successful midwifery practice experience**

- Find out the philosophy of care provided by the venue where you are being placed.
- Know the focus of the ward where you are being placed.
- Identify people that will support your learning and meet them early on.
- Show the support people your learning objectives and work together to achieve them.
- Don’t stand back and be shy; be proactive in your learning.
- Negotiate for clinical experiences, especially if they are the first time and/or new.
- Don’t worry if you haven’t learned the theory yet. Seize the opportunity and then reflect and debrief.
- Seek feedback every day. Formative feedback helps you to identify further learning.
- Identify your personal and professional boundaries.
- Be punctual, look smart and always wear your identification.
- Remember to thank the staff that support you.
- Have fun.

So far, an overview of the theory and practice has been discussed. Figure 1.3 shows competing interests faced by midwifery students and the need to keep a work–life balance. Some strategies on how to do this are presented in section 1.5.
1.4 Regulation and registration

**LEARNING OUTCOME 1.4** Examine how midwifery, as a profession, is regulated in Australia and New Zealand.

**National law in Australia**

The regulation and registration of midwives in Australia and New Zealand are similar; the difference is in the name of the regulatory authority. The *Health Practitioner Regulation National Law Act 2009* was introduced in Australia with the purpose of establishing a national registration and accreditation scheme for health practitioners. The aim of the Act is to protect the public. It is important to understand the objectives and guiding principles of the Act to recognise the professional responsibilities of the midwife.

A **Trans-Tasman Mutual Recognition Arrangement (TTMRA)** was agreed to in 1996 and came into force on 1 May 1998. This agreement permits a midwife who is registered to practise in Australia to also be able to practise as a midwife in New Zealand without further testing or examination, and vice versa.

**Australian Health Practitioner Regulation Agency**

The Australian Health Practitioner Regulation Agency (AHPRA) was established in 2010 to regulate Australia’s health practitioners in partnership with the national boards. There are 13 professions regulated by AHPRA, including nursing and midwifery. Each of these professions has their own board and midwifery is part of the Nursing and Midwifery Board of Australia. Midwifery does not have its own board in Australia. In New Zealand, regulation is governed by the Midwifery Council of New Zealand. AHPRA and the boards work in partnership with each having separate roles, powers and responsibilities as set out by the Act. The guiding principles state that all operations must be transparent, accountable, efficient, effective and fair (AHPRA 2016). Students enrolled in a university midwifery program should be registered as a student with AHPRA. This will involve a criminal history check. If the student has a criminal history record, they can contact AHPRA and see whether the conviction precludes them from becoming a midwife. Midwifery students register with AHPRA upon commencement of their program of study and then again on completion of their studies.
Nursing and Midwifery Board of Australia

The Nursing and Midwifery Board of Australia (NMBA) is a body corporate as defined by the Act and represents the State. It works in collaboration with AHPRA. The main function of the NMBA is to register midwifery students (and nursing students) and midwifery practitioners; develop standards, codes and guidelines for midwives; handle notifications and complaints; and assess overseas-trained practitioners who wish to work in Australia (NMBA 2016a). Some of the codes, standards and guidelines that govern practice are presented in figure 1.1.

When registering with AHPRA (and therefore the NMBA), there are mandatory registration requirements, such as a criminal history check and English language requirements. Registered midwives also need to provide evidence of 20 hours of professional development in one year and also recency of practice (NMBA 2016b).

In Australia, midwifery practice is governed by the *Code of professional conduct for midwives* (NMBA 2008a) and the *Code of ethics for midwives in Australia* (NMBA 2008b). These documents are essential reading prior to commencing the midwifery practice experience. The *National competency standards for the midwife* (NMBA 2006) is a document that provides the evidence of a student’s practice. These standards will be under review in 2017, and it is anticipated that they will become the midwife standards for practice in 2018. *A midwife’s guide to professional boundaries* (NMBA 2010) is also useful reading prior to starting the midwifery practice experience. Knowing how to be a midwife (dispositional knowledge) is crucial and knowing how to manage professional boundaries will protect the midwifery student and the woman, ensuring that practice is safe.

**ACTIVITY 1.5**

Read *A midwife’s guide to professional boundaries* (NMBA 2010) and identify behaviours that you think would fit within ‘disinterested neglectful relationship’, ‘therapeutic relationship’ and ‘boundary violations’.

With this in mind, think about what you would do in the following scenario:

You have cared for a woman and her family during her pregnancy, birth and postnatal period. The family want to reward you. They give you a cheque for $500 as they are so grateful, and insist that you take it.

Australian Nursing and Midwifery Accreditation Council

Students cannot register from entry to practice programs unless the program has been accredited as an approved program of study. This is done by the Australian Nursing and Midwifery Accreditation Council (ANMAC). There are two fundamental principles that ANMAC work by. The first is that the education provider is authorised to issue the qualification and has a process of continual evaluation. In the case of midwifery, this is the university (higher education provider). The provider must have current accreditation with the Tertiary Education Quality and Standards Agency (TEQSA) and also meet the Australian Qualifications Framework (AQF) that demonstrates the program of study is at the correct educational level (ANMAC 2014). The second principle is that there is a set of agreed competency standards against which the student is assessed.

In 2012 ANMAC reviewed the standards and released the current standards in 2014. The review took place with key stakeholders such as education providers, clinical venues and the public. The Midwife Accreditation Standards (ANMAC 2014) describe the nine standards that are assessed when a curriculum is submitted for accreditation. While all the standards are important, the one of most interest to midwifery students is Standard 8, as this focuses on the midwifery practice experience. It provides a clear direction in terms of the experiences that are mandatory for students to achieve, and some of these are outlined in the section on midwifery practice portfolio. Study programs also have mandatory content around knowledge (conceptual knowledge) and skills (procedural knowledge) in critical analysis,
reflective practice, professional advocacy, responsibility and accountability, research applications, legal and ethical issues, and decision making.

**Midwifery Council of New Zealand**

The Midwifery Council of New Zealand (2016) describes itself as the ‘guardian of the standards’. It is responsible for protecting the health and safety of the public by providing the mechanisms to ensure that midwives are safe, competent and fit to practise. This is done in the same way as in Australia with a robust registration process. There are codes of conduct and competency standards for entry to the Register of Midwives. The codes, standards and guidelines are similar to Australia’s, and there is a focus on Maori culture, cultural safety and the partnership model of care.

Again, it is the midwifery student’s responsibility to ensure they understand and have knowledge of the documents that govern their practice.

**The International Confederation of Midwives**

The International Confederation of Midwives (ICM) supports, represents and works to strengthen professional associations of midwives throughout the world. There are currently 130 midwives associations, representing 113 countries across every continent and more than 400,000 midwives globally. This includes the Australian College of Midwives (ACM) and the New Zealand College of Midwives (NZCOM). These two colleges provide professional support for midwives but do not have a regulatory role. ICM works in collaboration with the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO), the International Pediatric Association (IPA) and the International Council of Nurses (ICN).

ICM envisions a world where every child-bearing woman has access to a midwife’s care for herself and her newborn (ICM 2016). It has prepared core documents to guide member associations and governments, and to assist with education and regulation of midwives and their practice. These core documents are available on the ICM website and are essential reading for all midwives. These global standards, competencies and tools should be the foundation for all midwifery education, regulation and associations.

The World Health Organization has also produced the *Global strategic directions for strengthening nursing and midwifery 2016–2020* document (WHO 2016), continuing their leadership of the global midwifery agenda. The ICM has been involved with the development of these strategic directions and is active in the discussions and resolutions.

**Activity 1.6**

Visit the ICM website and find their core document on the philosophy and model of midwifery care. Read this document and refer back to your personal philosophy. Are there similarities in what you described? Are there differences? How would you align your philosophy of midwifery with that of the ICM?

**Australian College of Midwives**

The Australian College of Midwives (ACM) was founded in 1984 when a number of midwifery associations in various state and territory jurisdictions came together to create a national body for midwives. The ACM provides a unified voice for the midwifery profession, supports midwives in reaching their full potential and sets professional practice and education standards.

In 2015, a strategic plan was developed by the ACM, described as an outward-looking vision, which encouraged women to be strong and confident mothers. The ACM also has a range of position statements to assist practice, including statements on issues such as birthing on country, co-sleeping and bed-sharing, use of human donor milk, homebirth services, and maternal and perinatal care for asylum-seeking women held in detention.
ACTIVITY 1.7
Visit the ACM website and identity the main themes of the strategic plan.

New Zealand College of Midwives
The role of the New Zealand College of Midwives (NZCOM) is to be a voice for the midwives and women of New Zealand, with a focus on education, research and quality practice. One major difference of the NZCOM is the adoption of the partnership model of midwifery practice, first articulated by Karen Guilliland and Sally Pairman, which is a theoretical framework for midwives to understand the way they practise in New Zealand.

ACTIVITY 1.8
Visit the NZCOM website and read about the partnership model.

1.5 Qualities of midwives

LEARNING OUTCOME 1.5 Identify the personal qualities of the midwife.

Communication
There are many qualities that a midwife needs including excellent communication skills. Students will need to refine their communication skills so they can communicate effectively with the woman, her family and her friends (NMBA 2006). Students need to actively listen and respond to the woman, use language that she can understand, and talk to her about all things related to her pregnancy, birth and postnatal period. Students need to learn, accept, give advice and support women without judgement. They need to learn to trust and respect women and their families, and will need in-depth and tacit knowledge, competence and confidence to undertake the activities of a midwife.

A framework for communication and one that uses an inquiry base is Page’s five steps of evidence-based midwifery. The framework clearly focuses on the woman, who should always be at the centre of care (Page & McCandlish 2006). The five steps are outlined below.
1. Find out what is important to the woman (communication skills).
2. Use information from the clinical examination (procedural knowledge).
3. Seek and assess the evidence to inform decisions (conceptual knowledge, evidence-based practice and decision making).
4. Talk it through (communication and therapeutic relationship).
5. Reflect on the outcomes, feelings and consequences (dispositional knowledge, reflection).

The attributes in the brackets have been added to Page’s steps to show how education and practice have merged.

Emotional intelligence

Emotional intelligence (EI), as a concept, has been researched extensively within other professions but not within midwifery. It has been a major topic of debate since its appearance in the psychological literature in 1990 (Salovey & Mayer 1990). Patterson and Begley (2011) define emotional intelligence as:

possessing the capacity for motivation, creativity, the ability to operate at peak performance and the ability to persist in the face of setbacks and failures . . . the ability to recognise our own feelings and those of others and it enables us to manage emotions effectively in ourselves and in our relationships.
Patterson and Begley (2011) believe that raising the profile of emotional intelligence will increase the effectiveness and capacity of midwives to manage the constant change and challenges facing the profession. Emotional intelligence appears to foster better coping strategies, successful problem-solving, higher academic achievement, improved interpersonal relationships, and the ability to feel less anxious and be more resilient (Kun et al. 2012). Carragher and Gormley (2016) have taken this concept further, and, from their review of current evidence, concluded that emotional intelligence and leadership are concepts that belong together to allow professional undergraduate education programs to prepare practitioners who will provide compassionate, safe and high standards of care. Coupled with emotional intelligence is the concept of mindfulness, and Snowden et al. (2015, p. 152) suggest that training in mindfulness is associated with higher ‘ability’ emotional intelligence.

Mindfulness

Mindfulness is simply having knowledge of self, being aware of the present moment and knowing how to respond to a situation. Emotional intelligence and mindfulness are very much interrelated. There is very little in the literature about these concepts and they need to be explored further. However, it cannot be denied that being self-aware and knowing how to respond in a situation are critical in midwifery. An extreme example of this would be acknowledging personal feelings about death and knowing how to respond to a woman whose baby is born still. Sometimes, feelings are not known until the scenario occurs, so it is important to use reflection to assist in dealing with a situation.

Resilience

Resilience and mental toughness can foster clinical reasoning and critical decision-making abilities, which are vital in this profession (Strycharczyk & Clough 2015). Midwives must have the ability to
question and challenge practices, and make difficult decisions based on available evidence and the preferences of women in their care (Parsons & Griffiths 2007).

Hogan, Orr and Cummins (2015) suggest that midwives need the ability to bounce back, or respond to adversity, when working in this highly emotional profession. From the literature, they identified the ability to build resilience as crucial to midwifery practice, and managing coping and self-awareness. They also developed a flipped learning package, which was introduced to the curriculum in an Australian midwifery school, containing online activities with a focus on building skills in managing coping, self-awareness and resilience.

Working in midwifery is a unique experience, and many studies have considered socialisation in the culture of midwifery. Socialisation can lead to a loss of idealism and identification of negative aspects of care, which can decrease the ability to cope (Mackintosh 2006). Organisational socialisation, where interpersonal relationships are to be maintained, together with adaptation to the ward rules and culture, can create frustration and stress (Feng & Tsai 2012). Having emotional intelligence, mindfulness and resilience will help student midwives to succeed in the new cultural environment and cope with the shock of the ‘real world’.

1.6 Professional life

**LEARNING OUTCOME 1.6** Understand the demands of working within the midwifery profession.

Midwifery students often face challenging times during their demanding midwifery programs. This is good preparation for post-registration practice, and ‘mental resilience’ is needed for students and midwives alike. Students should engage with their midwifery program, use their negotiation and feedback skills, set priorities, be mindful and resilient, and look after themselves.

**ACTIVITY 1.9**

Read Lisa McTavish’s article about her experiences as a student midwife and think about what lessons you can learn from her story, and then write your own story.


Once all requirements for the midwifery program have been completed, students can register with the regulatory authority to gain their practising certificate. In Australia, there is an expectation that graduates will undertake a Transition to Professional Practice Program (TPPP) for 12 months, but in New Zealand, graduates will be able to work as a lead maternity carer immediately.

**ACTIVITY 1.10**

Think about a midwife you admire and who you feel is a good role model. Undertake a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) to identify challenges and support frameworks for you to achieve your goals. Keep this going for the whole course of your program. Keep adding to it and at the end, you will have a framework for becoming the midwife that you want to be.

Be aware that there may not be enough TPPP positions for all graduates. Be assertive and look in the private sector, and rural and remote areas for work. Over time, graduates may decide to undertake further study and gain a master’s degree or PhD. Graduates may also become a midwifery manager, researcher or educator. There are many pathways that can be explored.
SUMMARY

1.1 Identify your personal philosophy of midwifery.

The International Confederation of Midwives (ICM) has a philosophy of midwifery care that states that pregnancy and child-bearing are usually normal physiological processes that are profound experiences with significant meaning for the woman and her family. Students should write their own statement about their philosophy of midwifery and why they want to become a midwife.

1.2 Outline the role and scope of practice of the midwife.

An overview has been provided of the role and scope of practice of the midwife, and how midwifery students are educated and supported to become confident, competent, compassionate, accountable and autonomous practitioners in the global midwifery context. Although there are wide variations in education and scope of practice between countries, what is evident from the ICM scope of practice is that the midwife works in partnership with women to provide support, care and advice during pregnancy, labour and the postpartum period (Glover 2016). The practice of the midwife will be specific to the context of where the care is being provided.

1.3 Understand the complexities of midwifery education.

Midwifery education is challenging and usually takes three to four years of full-time study to complete. Having conceptual, procedural and dispositional knowledge will ensure that the midwifery student becomes a competent and safe midwife.

1.4 Examine how midwifery, as a profession, is regulated in Australia and New Zealand.

What it means to be a midwife, how to become a midwife and how to remain a midwife is entrenched in legislation and professional standards. The professional status of a midwife is protected, the regulation is complex and internationally compliant, the quality and academic rigour of pre-registration midwifery programs are assured, and the career choices are diverse. It is imperative to understand the frameworks of the profession and the regulatory bodies.

1.5 Identify the personal qualities of the midwife.

Having excellent communication skills, along with emotional intelligence, mindfulness and resilience, will assist with organisational socialisation.

1.6 Understand the demands of working within the midwifery profession.

Midwifery is a demanding profession but rewarding at the same time. It is an intimate profession where the midwife works closely in partnership with the woman and her family. The reward is being able to support the woman and her family in bringing new life into the world.

KEY TERMS

continuity of care experience (COCE) To ‘establish, maintain and conclude a professional relationship while experiencing continuity with individual women through pregnancy, labour and birth, and the postnatal period regardless of model of care’ (ANMAC 2014, p. 24).

emotional intelligence (EI) The capacity to understand, express and interpret emotions and to handle interpersonal relationships empathetically.

Trans-Tasman Mutual Recognition Arrangement (TTMRA) An agreement that permits a midwife who is registered to practise in Australia to also be able to practise as a midwife in New Zealand without further testing or examination, and vice versa.

WEBSITES

1 International Confederation of Midwives: www.internationalmidwives.org
2 Australian Nursing and Midwifery Accreditation Council: www.anmac.org.au
REFERENCES


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**ACKNOWLEDGEMENTS**

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