Contemporary issues in Australian midwifery regulation

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* The Australian Midwifery Action Project (AMAP) is a three year study funded by the Australian Research Council and five industry partners. It was set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services.

Abstract

This paper reports on research that examined the Nurses' Acts, regulations and current policies of each state and territory in Australia, in order to determine their adequacy in regulating the education and practice of midwifery. This is part of a three-year study (Australian Midwifery Action Project) set up to identify and investigate barriers to midwifery within the provision of mainstream maternity services in Australia. Through an in-depth examination and comparison of key factors in the various statutes, the paper identifies their effect on contemporary midwifery roles and practices.

The work assessed whether the current regulatory system that subsumes midwifery into nursing is adequate in protecting the public appropriately and ensuring that minimum professional standards are met. This is of particular importance in Australia, where many maternity health care services are seeking to maximise midwives' contributions through the development of new models of care that increase midwives' autonomy and level of accountability.

A lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally are identified. When these are considered alongside the planned development of a three-year Bachelor of Midwifery, due to be introduced into Australia in mid-2002, there exists an urgent need for regulatory change. The need is also identified for appropriate national midwifery competency standards that meet consumer, employer and practitioner expectations, which can be used to guide state and territory regulations.

We argue the importance of a need for change in the view and legal positioning of the Australian Nursing Council and all Nurses Boards regarding the identification of midwifery as distinct from nursing, and substantiate it with a rationale for a national and consistent approach to midwifery regulation.

Introduction

It is timely to review the current system of midwifery regulation in Australia. In the last decade the organisation and context for the provision of maternity services has changed considerably.

Major shifts in government policy direction and reforms across maternity care services have occurred as a response to community demand and evidence of the safety and satisfaction with midwifery care (Homer et al. 2001; Kenny et al. 1994; Rowley et al. 1995). As a result, new models of care have emerged that require midwives to work in more flexible arrangements rather than the 'shifts' of the traditional eight-hour salaried employee.

New working conditions are emerging reflecting increased autonomy and self regulation of practice and standards (Department of Human Services 1999a; Department of Human Services 1999b; NHMRC 1996; NHMRC 1998; NSW Health Department 1989; NSW Health Department 2000; Victorian Department of

Health 1990). Compounding this internationally and nationally is the increasing prominence of undergraduate (non-nursing) programs in midwifery.

The United Kingdom (UK) now prepares the majority of midwives in comprehensive three-year and four-year programs (Fraser 2000). Other Western countries such as the Netherlands, France, Denmark, Germany and Sweden have always educated midwives through three and four-year programs. These countries report some of the best standards of practice and clinical outcomes in maternity care in the world (Campbell & Macfarlane 1994; McKay 1993; Tew 1990).

In New Zealand, all one-year midwifery programs have now ceased. Nurses themselves who considered that their one-year program was inadequate in comparison to the three-year midwifery program initiated this action (Personal communication, Pairman 2000). With an increasing emphasis world-wide on the use of evidence to inform practice, policy making and the organisation of services, the midwifery profession is challenged to change and develop, in order to meet the needs of the community, governments and employers.

The changes described above have the potential to significantly affect the way midwifery is regulated and organised in Australia. Since World War ll, midwifery has been predominantly based in acute care hospitals and within nursing models of organisation and management (Barclay 1986). Changes to practice, education and regulation will be necessary if contemporary Australian midwives are to meet these demands and if the standard of midwifery care offered to Australian women is to be comparable to other Western countries.

The necessity for rethinking the regulation of practice to keep pace with changes in the organisation of health care and the role and scope of practice of the midwifery profession is obvious. This paper provides an overview of the regulation of midwifery in Australia. It examines and compares key factors in the various state and territory Acts, to identify their effect on contemporary midwifery roles and practices. The work aims to test whether subsuming midwifery into nursing within the current regulatory system protects the public and ensures professional standards are met. This is of particular importance in the current health care climate that is seeking to maximise midwives' contributions and expand their autonomy and level of accountability (Commonwealth Department of Health and Aged Care 1999; NHMRC 1996; NHMRC 1998; NSW Health Department 2000). A regulatory framework is required that clearly identifies midwifery and enables the necessary health services reform to occur in a manner that both protects the public and enables the appropriate education of the profession.

Background

In Australia, midwives and childbearing women have historically not had a strong voice in planning and implementing regulatory systems and public health policy (Barclay 1984; Barclay 1985a; Barclay 1995; Summers 1998). Midwifery has been subsumed into nursing since regulatory systems for nurses were set up in the 1920s (Bogossian 1998; Summers 1998). With few exceptions, nursing leaders have been required or have chosen to represent both nursing and midwifery and the interests of nursing have been privileged. Midwifery has been seen post World War II, as just one of the many specialities of nursing, similar to for example mental health, paediatrics or aged care (Barclay 1986). This has meant that, despite all the evidence linking improved maternal and infant health outcomes with autonomous midwifery practice (Department of Health Expert Maternity Group. 1993; Katz-Rothman 1991; World Health Organisation 1996), midwifery has declined as a separate profession since the 1920s and 1930s. Enactment of single nursing registers within some state and territory Nurses Acts over the past decade has further compounded this issue. Through the various Nurses Acts and regulations, reviewed in the 1980's (Barclay 1985b), in the 1990s (Bogossian 1998) and again for this paper, midwifery has remained 'invisible' in a legal sense in Australia.

In contrast, in many western countries midwifery has always been recognised as a discipline distinct from nursing. Recently, some countries such as the United Kingdom and Ireland have reasserted the value of this distinction (UKCC 1998; Government of Ireland 1998). The current UK registration statute is titled the *'Nurses, Midwives & Health Visitors' Act (1998)*, which clearly recognises the distinction between these disciplines. A recent major review of this Act has highlighted the need to:

"ensure that the public protection afforded by the Act is effective while not stifling developments in health care" (UK Health Department and JM Consultancy Ltd 1998), p6).

The midwifery profession in Australia is currently questioning inconsistencies and apparent failures of the current regulatory and education systems for midwives (Summers 1998; Tracy, Barclay, & Brodie 2000; Waldenstrom 1996). This follows serious concerns identified more than fifteen years ago (Barclay 1984; Barclay 1995) which, while continuing to be raised through a number of different forums (NSW Health Department 1989), have received insufficient attention from regulatory bodies, funders and policy makers (Commonwealth Department of Health and Aged Care 1999; NSW Health Department 1989; NSW Health Department 1998; NSW Health Department 2000; NSW Health Department 2000). These concerns are exacerbated by, and should be considered in the light of, the move from hospital-based midwifery education to the tertiary sector and an absence of any formal evaluation or analysis of the impact of this move on standards of care and practice.

The consequences of changing service delivery models and the shifting of health care from hospitals to the community, a common trend in many western countries, alter the role, scope of practice and education of midwives. Australia's high standard of maternity care assumes the presence of qualified midwives. They offer safety and support for women in childbirth and the postnatal period in collaboration with medical colleagues, and increasingly as primary providers of maternity care in their own right (NHMRC 1996; Australian Medical Workforce Advisory Committee 1998).

Concerns about the educational standards of midwives are also associated with global changes and reforms in the way midwifery is regulated (Department of Health UK 1998; Jowitt 2000; Lilford 1993; Norman 1998; Rogers & Ryan 2001; UK Health Department and JM Consultancy Ltd 1998). The highest standards should be employed in the regulation of both midwifery and nursing in order to optimise protection of the public and to promote and maintain public trust and confidence with the professions. Across Australia, the regulatory Boards (In this paper Nurses' 'Boards' includes the Queensland Nursing Council) of each state and territory regularly review their systems and processes in order to meet their objects. Boards have a key responsibility to communicate to consumers the competency standards that they can expect of nurses and midwives (Australian Nursing Council Inc. 2001).

Through these endeavours the Australian Nurses' Boards aim to promote consumer involvement, high professional standards, greater protection for the public and better regulatory practice. There are however profound differences in the way this is done. The results and comparability of current processes in a climate of mutual recognition is problematic. It is timely that a more modern regulatory framework that encompasses self-regulation, personal accountability and agreed national standards be developed.

Aim

The aim of the research reported in this paper was to analyse the Nurses' Acts, regulations and current policies of each state and territory to determine their adequacy in regulating the education and practice of midwifery in Australia.

Method

Each of the eight statutes were obtained electronically and downloaded from The Australasian Legal Information database (AustLII). These were analysed for similarities and consistency in structure, format, content and relevance. An overview of the current legislation that regulates midwifery in all states and territories was constructed from this data.

A systematic content analysis that included the search for the basic attributes and common features found in most forms of professional regulation was conducted.

Themes, contrasts, gaps and inconsistencies were highlighted and compared across each of the statutes. Diversity within these basic attributes and their relative importance to each other was analysed and reported only when this appears to have negative consequences or outcome. A comparison of midwifery regulation documents from the United Kingdom, Europe and New Zealand, as well as some of the recent published literature, was made to verify assumptions and contrast Australia with international standards of midwifery education and practice.

The authors consulted with a nurse-lawyer, which enabled a number of inconsistencies and anomalies to be identified. This resulted in the drawing of a number of conclusions about the Acts and regulations as they currently exist including certain limitations and concerns.

Two key questions were asked of the regulations:

- What are the current laws, regulations and policies, which govern midwifery practice and education and how do they compare between states and internationally?
- What are the features of the current system of regulation of education, practice and competency of the midwifery profession?

The authors hypothesised that, within the current system of nursing regulation through the state and territory Boards, there is confusion about the role of the midwife with a lack of consistency that challenges the legitimacy of the current Acts and their capacity to protect the public.

Results

Midwifery education regulation

Currently there is wide discrepancy between midwifery educational programs across the country with concerns that current midwifery programs in Australia do not meet recognised international competency standards for midwives (Leap 1999a) (AMAP unpublished data, July 2001) or even nationally agreed baselines. This is confirmed by examination of state and territory regulations with regard to approval of courses and institutions. For example, in New South Wales, all students of midwifery are required to meet the particular competencies of a midwife as set out by the Board plus complete a list of clinical requirements including twenty births, twenty abdominal palpations and ten vaginal examinations (Nurses Registration Board of NSW 2000). In some states however, such as South Australia, Western Australia and Queensland competency based assessment of students has completely replaced a system of minimum clinical requirements for qualification. In South Australia, student midwives are assessed through a 'competency- based approach' that does not stipulate a specific number of clinical requirements, hours or shifts in a particular area (Glover, James, & Byrne 2001). The Nurses Board of Northern Territory require midwifery students to master three skills, chosen from a list of six or eight, in each of four different clinical areas (Nurses Board of Northern Territory 1989). Unpublished data reports that some midwives have been able to register after completing as few as five births (AMAP data, unpublished 2001). One recent publication reports how graduates educated through this 'competency based approach' may not be employable as midwives in the same small country hospital where they completed their clinical placement because they are not considered to have enough experience (Glover, James, & Byrne 2001).

There is a wide range of clinical practice requirements, which are developed locally by each Board through 'consultative' processes. These vary and they reflect the priorities and expectations of the individual group, rather than any agreed national formula or standard for consultation and review. Large differences in the number of theoretical and clinical hours of programs are also compounded by the variability that exists in the amount and type of clinical experience available to students. In addition, in the absence of national standards, labour force shortages make these local processes vulnerable to manipulation, with potential to undermine practice standards even further. The Australian Midwifery Action Project (AMAP) is conducting a survey of all universities currently offering midwifery education leading to authority to practice. This research will highlight the lack of comparability of current midwifery curricula, including number of clinical and theoretical hours, assessment of competency, duration of course and nomenclature of awards.

To date, the Australian nurses boards have not been able to agree on universal adoption of the Australian College of Midwives Competency Standards for Midwives (Australian College of Midwives Inc. 1998). By late 2001, three out of eight Boards (New South Wales, Western Australia and Northern Territory) had not adopted the midwifery competencies specifically developed by the profession (Personal communication, ACMI, 2001). This is problematic though not surprising given the variable composition of the Boards, the lack of consistency with regard to midwifery representation and the wide variation in standards of regulation. Table 1 shows how the various Boards are constituted with only two states, NSW and WA specifically requiring within the Act that a midwife actually be a member of the Nurses Board (Nurses Board of Western Australia 1992; Nurses Registration Board of NSW 1991).

Table 1: Composition and structure of the eight Nurses Boards and Councils including level of midwifery representation

State/Territory	Constitution of the Board	Chairperson of the Board
Australian Capital Territory	Chairperson + 4 other members not more than 2 to be EN appointed + 4 members elected in accordance with Health Professionals Boards (Elections) Act. Must be RN or EN entitled to practise as such for 3 years in any State or Territory prior to this time	Must be RN as does deputy
New South Wales	13 members appointed by Governor: 3 elected RNs; 1 EN; 1 RN authorised to practise midwifery. 1 RN from NSW Nurse's Association; 1 RN from NSW College of Nursing; 1 RN from Minister of Health; 1 RN educator of nurses, nominated jointly by Minister School Ed & Youth Affairs and Minister of Further education, Training and Employment; 1 RN Psych nurse, nominated by Minister; 1 barrister or solicitor. 2 consumers	Not specified
Northern Territory	8 members: RN responsible to Chief MO for nursing services in Territory; Person in charge of medical services at Darwin Hospital; RN in charge of nursing at Alice Springs Hospital; RN in charge of nursing services at Darwin Hospital; 4 persons appointed - 1 RN, 1 qualified practising nurse educator; 1 RN and 1 EN nominated by ANF	RN responsible to the Chief Medical Officer for nursing services in Territory
Queensland	13 members: 5 RNs; 5 nurses chosen from panel of names submitted by associations accepted by Minister as representatives of nurses; 1 consumer; 1 lawyer; Executive officer of the council	Governor in Council appoints member of the board who is not an officer of the public service
South Australia	11 members:1 RN nominated by Minister - presiding member; 5 RN or EN elected; 1 Medical practitioner; 1 lawyer; 3 people nominated by Minister who are not nurses, lawyers or doctors, at least one woman and one man	Appointed by Minister
Victoria	12 members; 9 must be RN - 2 must be registered under Division 2; 1 lawyer; 2 non nurses	President and Deputy appointed by the Governor in council, must be RNs
Western Australia	12 members appointed by the Minister: 2 ANF[1] midwife[2]; 1 Psych nurse[3]; 1 RCNA WA[4]; 2 EN[5]; 1TAFE[6]; 1 Curtin[7]; 1 Edith Cowan[8]; 1 Minister Consumer Affairs[9]; All members to be natural persons and have 3 years standing in practice	Presiding member appointed from members by Minister and after consultation with the Board
Tasmania	7 members nominated by the Minister and appointed by the Governor: 5 practising nurses with ability to fulfil the Board's objectives; 2 persons who are not nurses who represent the interests of persons who use the services of nurses.	A practising nurse, appointed by the governor

Explanations for Table 1:

1. Australian Nursing Federation nominates two representatives who are registered on Division I of the register
2. The Australian College of Midwives Incorporated (WA Branch) nominate a person with knowledge of and experience in midwifery and who is registered on Division 1 of the Register.
3. The Psychiatric Nurses Association nominate one representative
4. Royal College of Nursing WA Chapter nominate one representative with knowledge and experience in nursing administration

5. The Federated Miscellaneous Workers Union of Australia nominates two representatives who are enrolled nurses
6. The Executive Director of TAFE nominate one representative who has knowledge and experience teaching nurses to be registered under Division 2
7. The Chancellor of Curtin University nominates one representative who teaches nursing at that university
8. The Council of Edith Cowan University nominates one representative who teaches nursing at that university
9. Minister, Consumer Affairs nominates one person who has consumer representation experience

In a climate of maternity services reform with increasing prominence of midwifery, it is inappropriate for Boards to continue to state that the conceptual framework and course philosophy for midwifery education programs must have a 'nursing focus' (Nurses Board of South Australia 1997; Nurses Board of Western Australia 1993). Similarly, regulations that require curricula based on 'nursing theory and practice', with teachers of programs having a 'nursing background' (Queensland Nursing Council 1993; Nurses Board of South Australia 1997), are out of step with contemporary practice. Quite apart from the impact on content and syllabus, this terminology alone, emphasises inconsistencies of Australian regulation with midwifery education nationally and internationally.

This approach does not ensure that the community is either protected through practice or receive optimally educated practitioners. It also disadvantages both students and universities in terms of potential international exchanges, recruitment of high quality academics and the marketing of courses in other countries. There are also concerns about how these issues contribute to a situation where Australian midwives, unlike nurses or medical practitioners, routinely have to undertake further education if they wish to practise in other countries (Leap 1999b).

Reviews of midwifery educational and clinical facilities conducted by the Boards are not required by all states. Where they are required (Nurses Board of Western Australia 1993; Nurses Registration Board of NSW 1997), there is no consistency in requirements for how these visits are to be performed or the qualifications of persons performing them. There is no evidence of any formal link or expected compliance between states and territories. This is in spite of the Australian Nursing Council Incorporated (ANCI) stating that one it's key functions is to:

> *'lead a national approach with State and Territory nurse regulatory authorities in evolving standards for statutory nurse regulation which are flexible, effective and responsive to health care requirements of the Australian population'*
> (Australian Nursing Council Inc. 2001).

In contrast, in the United Kingdom, Canada and New Zealand regulatory Boards use agreed national criteria to accredit curricula as well as teachers, facilities and services. Robust validation of standards of midwifery education and midwifery practice settings, determined by the profession, in consultation with consumers and in keeping with changes and new directions in health service delivery, is expected (English National Board for Nursing 1998; Nursing Council of New Zealand 1996; Ontario College of Midwives 2001). In addition in the UK, health care facilities are required to demonstrate evidence of 'keeping up to date with government policy direction and principles of care' (English National Board for Nursing 1998).

Concerns with the quality of the current Australian midwifery workforce have recently been articulated (Tracy, Barclay, & Brodie 2000; Waldenstrom 1996) and these will require addressing within the regulations as well as by education and service providers as well as professional bodies1. All current assessment regulations for midwifery fall well short of those required by the regulating bodies of other industrialised countries, for example the requirement in Europe for midwives to participate in at least 40 births (European Community Midwives Directives 1980) and in Canada 60 births (Ontario College of Midwives 2001), before receiving registration.

It is crucial that agreed standards in education are established nationally that are consistent across curriculum and regulation and that provide the baseline for ongoing practice regulation.

Midwifery practice regulation

Practice standards are another important aspect of regulation and exist alongside the growing emphasis upon quality assurance and evidence based protocols and policy in health care.

In Australia, course accreditation standards, evaluation systems and processes to ensure standards of midwifery and nursing education and practice, vary from state to state. There is not an explicit link, agreed minimum standards or any benchmarking possible between the different Boards, as might be expected through the examination of regulations. This is not 'managed' consistently either, with some Boards or Councils for example, not having an identified professional officer in midwifery or even an equivalent person responsible for midwifery as one of several portfolios. Arguably, Board personnel with a broad generalist role would not be able to keep up to date with relevant issues such as evidence based midwifery practice and policy development.

Two of the key objectives of the Australian Nursing Council are to:

- develop and be guided by a strategic view of statutory nurse regulation in the national and international contexts;
- apply a continuous quality improvement approach to its activities (Australian Nursing Council Inc. 2001).

The actual structure, processes and outcomes related to these objectives with regard to midwifery practice is not evident in the current legislative documents available to the profession and the public. See for example the Annual Report of the Australian Nursing Council Inc. (2000) and the website of the Council (Australian Nursing Council Inc. 2001) in which midwifery is not identified at all.

Identification and recognition of midwifery

All Nurses Acts in Australia currently see midwifery as a 'branch' or 'specialty' of nursing and therefore refer to midwives as nurses. This has serious implications for the regulation of those midwives who have never been nurses and who would not seek to hold themselves out as nurses. There are anecdotal reports of increasing numbers of 'direct entry' midwives from countries such as England, New Zealand and Canada seeking registration in Australia. In some cases these persons are being 'licensed' to practise both as midwives and as nurses. In one case, a midwife who was refused registration in one state in Australia proceeded to obtain registration in New Zealand without difficulty. Under mutual recognition (Commonwealth of Australia 1992), this midwife could register in her new home state in Australia who had originally refused to register her. (Personal Communication, 2000).

In all but three states, midwives are automatically presumed to be competent as a nurse and practise under a Nurses Code of Ethics. To date, three states (Victoria, Queensland and Tasmania) have also developed their own individual codes of practice for midwives (Nurses Board of Victoria 1999; Nursing Board of Tasmania 2000; Queensland Nursing Council 2000). It is unreasonable, unsafe and probably unlawful to expect people who have never identified as nurses to self regulate as nurses within documentation that, in some parts of Australia, does not explicitly include the nomenclature of midwifery and midwife. It is therefore inappropriate to simply suggest within the statutes that nomenclature for midwife/midwifery may be used interchangeably with nurse/nursing (Nurses Board of South Australia 1999). It is unacceptable, irrelevant and arguably dishonest to ask a midwife at registration, to describe her/his previous experience as a nurse when, she/he has only ever worked as a midwife. Increasingly, this also applies to midwives who no longer work in nursing and identify solely as midwives, and to midwives who have only very occasional access to midwifery practice.

Each of the state and territory Acts provide for the Boards to have specific powers enabling the practice of midwifery to be 'controlled'. These powers appear to be directed at controlling any attempt by non authorised persons from practising midwifery, although midwifery practice itself is not defined. In all states midwifery requires a separate authorisation from the Board, following registration as a nurse. Practising midwifery is illegal unless the person is a medical practitioner, or a student nurse, midwife or doctor 'under supervision'. Where the term 'supervision' is used, it is not always defined. Only the Nursing Acts of Tasmania (1995) and South Australia (1999) attempt to do so by providing an interpretation of the term 'supervision' to include: "oversight, direction, guidance and support" with the South Australian Act (1999) adding to this...."whether given directly

or indirectly". The New South Wales Nurses Act (Nurses Registration Board of NSW 1991) states that a person must not practise midwifery without authorisation unless they are a medical practitioner, a person rendering emergency care or:

> *"any medical or nursing student, or accredited nurse, acting under the supervision of a registered nurse authorised to practise midwifery, or the supervision of a medical practitioner"*
> (NSW Nurses Act 1991 Part 2 Section 7).

The public have no way of determining the efficacy and safety of particular arrangements that may be under the auspices of midwifery 'supervision'. It is important that consumers are able to identify qualified persons and make 'informed choices' around their maternity care options, particularly in NSW where they may be receiving care from 'any' level of nurse or medical student under 'supervision' (NSW Nurses Act 1991 Part 2 Section 7). Protection of title is important in contributing to the public's perception of the distinction between the professions of nursing and midwifery. As stated in the NSW Health Issues Paper (NSW Health Department 1999) specifically prepared to assist in a review of the Nurses Act in that state:

> *"The objective of title restriction is to protect the public by ensuring that consumers are able to identify qualified persons"* (p26).

In addition to protection of the title 'nurse', which is universal in Australia, four states (NSW, ACT, Victoria and SA) restrict the use of the title 'midwife'. Protection of title is of little use if the documentation produced by the Boards, is confused and implies that nurses and midwives are one and the same. For example, whilst not enshrined within law, the Boards of NSW and Tasmania both state that they 'accept' the current definition of a midwife as endorsed by the World Health Organisation' (Nurses Registration Board of NSW 2000; Nursing Board of Tasmania 2000). Significantly, this definition states that "a midwife is a person" and does not in any way state that a midwife must also be nurse (International Confederation of Midwives 1990).

Table 2: Purpose of the Act and nomenclature used for recognition of nurse, nursing, midwife and midwifery for each for each state and territory

Act	Purpose of Act	Interpretations within the documents
New South Wales 1991	To regulate the practice of nursing and to repeal the Nurses Registration Act 1953	RN: person reg. under this Act. Person authorised to practise midwifery must be entitled to be registered nurse
Australian Capital Territory 1988	To provide for the registration & enrolment of nurses, supervision of nursing education and standards, and related purposes	RN: person reg. as general nurse, mental health nurse, or midwife; 'practising' in this Act means practising in any branch of nursing
Northern Territory 1984	To provide for schools of nursing and the registration and enrolment of nurses	Nurse: person reg. or enrolled under the Act. General nurse: person whose name appears on the registry under general category of nursing; Midwifery nurse as above but on category of midwifery.
Queensland 1992	To provide for registration and enrolment; practice of nursing, education of nursing and related purposes S 3 Objective : to make provision for ensuring safe and competent nursing practice	Nurse: registered or enrolled nurse. Midwife: person authorised to practise midwifery.Nursing Course: course to educate persons in nursing and midwifery. Nursing Practice: includes midwifery, psychiatric, and any other area of nursing practice. Nursing qualifications: includes midwifery, psychiatric and any other area of nursing.
South Australia 1999	To provide for Registration and enrolment of nurses, regulate nursing for purpose of maintaining high standards of competencies & conduct by nurses, to repeal 1984 Act, other purposes	Nurse: person reg or enrolled under Act Midwife: person authorised under this Act to practise midwifery. Midwifery: care assistance, or support provided to a mother or child in relation to pregnancy or the birth of a child. Special practice areas: midwifery, mental health nursing, any other area of nursing recognised by the Board as being special practice area
Victoria 1993	To protect public by providing registration for nurses & investigation into professional conduct and fitness to practise of RN; to establish Vic Nurses Board; repeal 1958 Act, to provide for other related matters	General nurse / maternal and child health nurse / midwife means person registered under Division 1 of the register;
Western Australia 1992	To provide for regulation of the practice of nursing, registration of persons as nurses, repeal 1968 Act and related purposes	Nurse: a person registered; Speciality means a particular branch of nursing recognised by the Board as requiring particular qualifications approved by the Board
Tasmania 1995	To provide for the registration and enrolment of nurses, the regulation and practice of nursing, the repeal of the Nursing Act 1987 and for related purposes	Nurse: a person registered or enrolled as a nurse; midwife means a registered nurse authorised to practise midwifery; practise means practise nursing; midwifery is a restricted area of nursing practice

The need for a clear distinction between midwifery and nursing is underpinned by the fact that, following completion of an appropriate educational preparation and registration within the Act, midwives are *practitioners in their own right*. This differs for all other areas defined as specialities in nursing. Within the Acts, midwives are not required to consult with doctors unless there is a medical need. Midwives are qualified to provide primary care across a clearly defined spectrum of time in a woman's life. The period of care is usually the antenatal, intra-natal and postnatal period up to either twenty eight days or six weeks following childbirth. In most developed countries other than Australia, this period of time is explicit within the regulations which make provision for midwives to have legal responsibility for this clear and well defined sphere of practice (UKCC 1998).

The internationally recognised definition of a midwife states that:

"A midwife is a person who, having been regularly admitted to a midwifery educational program, 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 post partum 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". (International Confederation of Midwives 1990).

Other issues of quality in regulation

Determination of recency of practice is another area of regulation where there is significant inconsistency between the various regulatory systems. In some states registration continues indefinitely, even if a midwife is no longer practising or has not practised for many years (Nurses Registration Board of NSW 1991). 'Practising' is not defined or clearly identified as 'clinical practice' although one authority provides a 'limited' registration to allow for research or teaching only (Nursing Board of Tasmania 1999). Every state except NSW has a '5 year clause' that requires a midwife to complete a re-entry program (often in nursing). Most allow continuation of registration as a midwife even if working exclusively as a nurse with an implied assumption that practising as a nurse also keeps an individual up to date in midwifery. Whilst it may be argued that recency of practice is the responsibility of the individual and or the employing authority, in the current climate of workforce shortages, it is possible that such expectations are not consistently adhered to. Similarly, in such situations of workforce shortages, midwives who have not practised nursing for many years, or even not at all, may be sent to work in nursing areas. Again, protection of the public and adequacy of regulatory standards is questionable and should be a matter for concern.

To date there is not universal agreement regarding nationally competency standards for midwifery practice or education in Australia, and as such continuing professional competence is addressed in a variety of different ways by each of the Boards. In some states (for example SA), midwives are required to declare competence as a nurse using the Board approved competency standards for the registered nurse (Australian Nursing Council Inc. 1998). The principle mandate of the ANCI (of which all state and territory Nurse Boards are stakeholders), is to lead a national approach in developing common standards for statutory nurse regulation. Since inception and to date the ANCI have shown no evidence of endorsing national standards for midwifery practice or education. ANCI continue to utilise nursing standards in their assessment of overseas applicant's suitability for registration and competence to practice midwifery, and in assessment of the midwifery educational programs these applicants have undertaken. This is inconsistent with the contemporary international approach to midwifery regulation

Currently, only one Board requires practising midwives to declare competency on an annual basis using the ACMI Competency Standards for Midwives as the standard (Australian College of Midwives Inc. 1998; Nursing Board of Tasmania 1999). Of concern is one Board (NSW) that does not require nurses or midwives to declare any degree of competence before receiving annual renewal of registration.

Concerns about the regulatory standards of education of new midwives may also be applied to the re-education of midwives returning to the workforce. Currently, in Australia there is no evidence of any requirement for refresher programs to be of a certain standard with regard to content, duration or outcome measures. In 2000 a change in the Tasmanian regulatory framework demonstrated how many midwives do not re register when stringent mechanisms are put in place that require them to declare competence in their field. Section 5.2 in the code of Practice for Midwives in Tasmania states:

"All midwives are responsible and accountable for their own practice. They must act within the sphere of midwifery practice and are expected to maintain the necessary competence for safe and effective practice. The standard in Tasmania is the ACMI Competency Standards for Midwives". (Nursing Board of Tasmania 2000).

In one year following the release of the Competence to Practise Policy (Nursing Board of Tasmania 1999) the numbers of practising midwives registered in Tasmania dropped markedly (Street 1998). This is further evidence that loose legislation is not enabling the Boards to meet the objectives of the Act. This action also adds strength to the argument that midwives or nurses will choose not to work in areas where they are not recently familiar or competent, when given the opportunity to declare their self competence and individual scope of practice for safe care. Table 3 describes current regulation standards by State and Territory regarding declaration of competence, existence of a code of practice for midwifery, and recency of practice requirements for midwives in Australia.

Table 3: Annual declaration of competence requirements, existence of recency of practice clause and code of practice for midwives in Australia, by State and Territory..

State/Territory	NSW	NT	ACT	QLD	VIC	SA	WA	TAS
Annual declaration of competence required -	no	no	no	yes	yes	yes	no	yes
Type of competency: Ns = nurse Mid =midwife	-	-	-	Ns	Ns	Mid	-	Mid
Recency of practice clause (5 years)	no	yes	yes	yes	yes	yes	yes	yes
Code of practice for midwives	no	no	no	yes	yes	no	no	yes

The issues of recency of practice and continuing competence are both complex and important. In terms of protecting the public this should reflect a national standard to allow for the mutual recognition of accreditation from other states and territories around Australia. It appears essential that Australia moves toward a national system whereby midwives and nurses must declare that they have maintained competence in one or both disciplines and that they have determined for themselves that they are safe to practise. The Acts should ensure that standards are employed rigorously and appropriately in the regulation of both professions in order to protect the public and promote and maintain standards of care. This is an important principle if Boards do not see their role to monitor practice standards in any other way. These issues raise significant questions surrounding refresher and re-entry programs including who provides them, as well as costs, content, standards and audit and quality measures in place.

Employers need to be able to expect that a midwife registered in another state is of a similar standard to that expected in the state in which they seek to practise. This is assumed to be more straightforward since the Mutual Recognition legislation was enacted in 1992 (Commonwealth of Australia 1992). This Act was introduced to address some of the difficulties created by state and territory differences and to facilitate the registration process for health professionals moving across borders. The effect of this legislation was supposedly to provide uniformity and consistency in addressing prerequisites for registration and streamlining the process of registration for practitioners who moved from one state to another. Despite this Act, there remain significant differences in the relevant legislation between the states and territories that is highly problematic. Similar concerns have recently been raised regarding the regulation of nursing in Australia in which the author identifies the need for the development of a national template for the regulation of all health professionals (Bryant 2001).

Current context

There is recognition by some employers as well as researchers of the need for the standard of midwifery education to be reviewed in light of developments in models of care, as well as concerns about standards of practice and recruitment and retention of midwives (Tracy, Barclay, & Brodie 2000). Under the auspices of the Australian College of Midwives (ACMI) several universities across Australia are developing innovative collaborative approaches to midwifery education that include a set of national standards for the accreditation of three-year Bachelor of Midwifery programs. This form of midwifery education will be developed in Australia over the next few years, with eight Universities reporting that they intend to commence three-year programs in 2002 and 2003 (Australian College of Midwives Inc. 2001; Leap 2001). In March 2001, the Australian College of Midwives (ACMI) Bachelor of Midwifery National Taskforce distributed in draft form, *Standards for the Accreditation of Bachelor of Midwifery Programs* to the eight Nurses Boards. This is part of the ACMI's attempt to develop standards and a national framework to ensure excellence and compatibility in the accreditation of midwifery education programs used across the country. It is hoped that eventually, these standards will be used for approval of all courses and education providers in all institutions offering courses leading to registration as a midwife. At the current time however, as the current Acts are constituted, Nurses Boards are not obligated to adopt these standards. It is proposed that a peer review panel constituted and convened by the ACMI will make recommendations to the registering authorities for course approval (ACMI, Personal communication, 2001). This most significant and formal attempt by the midwifery profession to seek national recognition of midwifery standards and competence will challenge the current regulatory system and further highlight its limited capacity to respond at a national level.

Conclusion

It is clear from the analysis of the various acts and regulations affecting midwifery in Australia that serious inadequacies exist. The lack of consistency and evidence of discrepancies in the standards of midwifery education and practice regulation nationally, raise concerns about the capacity of the current statutes to protect the public adequately and ensure that minimum professional standards are met.

The development of national standards in midwifery education and a three-year Bachelor of Midwifery intensify the urgent need for regulatory change to bring Australia into line with other Western countries. Appropriate national midwifery competency standards that meet consumer and practitioner expectations and that can be used to guide state and territory regulations, are urgently needed.

Membership of the ANCI and all Boards of the future will need to recognise midwifery as distinct from nursing in order to ensure that 'profession specific' issues are addressed by the relevant group, with involvement of all key stakeholders. Midwifery and consumer representation should be evident on all bodies concerned with midwifery practice and education standards as well as with peer review and complaint mechanisms regarding the professional conduct of midwives. Currently this is neither consistent nor effective nationally. Specific midwifery representation is reflected in various ways, through board membership, the existence or otherwise of practice review committees and ad hoc processes of consultation with the professional midwifery and consumer groups.

The Boards have a role to play in educating the public to understand regulation and to enable discrimination regarding the significance of the title 'midwife' in terms of the role, as well as the different body of knowledge and scope of practice of midwives. The public needs to be aware if they are receiving care from a midwife, a nurse, a doctor or a student of any health profession. Protection of title is of little importance unless the public is educated to understand the significance of the title and how they are protected under the Act. Nomenclature should be addressed so that midwifery practice is clearly identified and to enable the regulation of midwives who are not nurses or who are no longer or have never been competent to practise in both professions. The skills and practices of each profession are distinct and different and the public has a right to this information. Any revision of regulation should ensure that the nomenclature refers to nursing or midwifery distinctively so that the public and empl0yers can be properly informed.

The ANCI have been responsible for a range of initiatives that demonstrate their commitment to and achievements for the profession of nursing. These include the development of a Code of Ethics for Nurses; a Code of Professional Conduct for Nurses and National Nursing Competency Standards for the Registered and Enrolled Nurse. It is essential that these same endeavours occur for the midwifery profession, for both midwives and consumers of maternity care across Australia. Universal adoption of the ACMI Competency Standards for midwives and a national Code of Practice and Code of Ethics for midwives would be an appropriate move forward in addressing some of the inadequacies and discrepancies identified. If self- assessment of competence is to be adopted universally, processes of maintenance and self- declaration must be established and recognised as national minimum standards. It would be desirable for the Boards, in partnership with ACMI, to explore these as well as the international systems and mechanisms for maintenance of midwifery standards to determine what constitutes appropriate professional activity and the best way forward regarding policy on these crucial issues.

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