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DIRECT ENTRY TO MIDWIFERY

DESPITE the support of the English National Board for Nursing, Midwifery and Health Visiting, a recommendation for such courses from the Department of Health and Social Security, the backing of the Royal College of Midwives and the Association of Radical Midwives, encouragement from various lay and 'consumer' groups, and press eulogies, direct entry midwifery training is only available in one school. Several other schools are planning or considering such programmes, but the progress is slow. To investigate this paradox, and to research all aspects of direct entry midwifery training, the ENB obtained funding from the DHSS and commissioned the Department of Educational Studies at the University of Surrey to carry out an independent study. These two articles report on some of the findings of the study – the first gives a brief historical background and reports on the current state of development of direct entry midwifery training programmes. The second will look at some of the areas which will be important in determining the courses of the future – the potential candidates and educational issues.

HISTORICAL AND IDEOLOGICAL BACKGROUND

Arguments about how a person should be trained are based on assumptions and beliefs about what skills and knowledge the qualified person needs and should have, which in turn depends upon her role. Those who see midwifery as a 'separate tree' feel there is a need for a distinct and special training. There is often a belief that training a 'different sort' of midwife will improve and change the delivery of care and the actual role. Some feel that nurse training is actually undesirable as a preparation for midwifery, others that the present role of a midwife requires her to have nursing knowledge, and that nursing training is an important foundation for becoming a midwife.

These assumptions and beliefs are rooted in history. On the one hand, there was the gradual erosion of the status of the direct entrant and the change from the practice of midwifery as a separate profession to 'a branch of intensive care nursing'. On the other hand, there is the tradition of the midwife as a practitioner in her own right, and the current trend of 'de-medicalising' childbirth. From 1906 until 1916, there was a single path for nurses and non-nurses to enter midwifery – a three month course. In 1916, this was changed to three months training for nurses, and six months for non-nurses. The training was lengthened in 1926 (six months for nurses and a year for non-nurses), 1938 (a year and two years respectively), and 1981 (18 months and three years). The increase in training time acted as a disincentive to direct entrants. Other influences on the declining number of direct entrants were various reports such as Stocks[1], Salmon[2] and Briggs[3] and the increasing hospitalisation of childbirth. Figure 1 illustrates how the proportion of direct entrant student midwives changed over the years.

DECISIONS FOR OR AGAINST DIRECT ENTRY MIDWIFERY TRAINING WERE USUALLY BASED ON PERSONAL EXPERIENCE OR OPINION — INDEED THE SAME FACTS WERE USED TO 'PROVE' THE CASE FOR OR AGAINST NON-NURSE MIDWIVES

The last decade has seen a swing away from the medicalised model of childbirth towards natural birth. Writers such as Inch[4] and Kitzinger[5], as well as an increasingly high media profile for childbirth related topics and the feminist lobby have increased interest in the role of the midwife as the specialist in normal childbearing, particularly non-nurse midwives, who are seen as 'untainted by the sickness model'.

Another influence was the increasing contact with Europe and its different traditions and trainings for midwives.

The '80s also brought a flood of educational documents relating to nursing and midwifery – the RCN Commission on Nursing Education[6], the ENB Strategy Document[7], RCM's Role and Education of the Future Midwife[8], ARM's The Vision[9] and Project 2000[10]. The midwifery profession reacted with surprising vigour to the initial Project 2000 proposals to incorporate midwifery as a branch of nursing. Seemingly challenged and stimulated by the Project 2000 debate, midwives moved on to seek an increase in specialist direct entry midwifery training programmes. To accelerate development one must first know what influences it, and determine the stage it has reached so far. The following section briefly describes the national picture regarding direct entry midwifery training and the factors influencing decisions on its implementation.

PRESENT NATIONAL SITUATION

The excellent response rate to the survey of all regions, districts and schools (100%, 91% and 99%), and the co-operation of a multitude of interviewees (managers, tutors, student midwives, clinical staff, representatives of statutory and professional organisations, and lay agencies, and so on) ensured that a comprehensive national picture was gained. Overall, there was considerable interest expressed in direct entry midwifery training. Figure 2 shows the policies of regions and districts. Figure 3 shows the actual situation at the time of the survey.

A slight shift was evident in the position of several health authorities during the course of the project, which can be largely attributed to three factors. At the beginning of the study, many of the RHAs were in process of investigating midwifery staffing and

education in order to formulate strategy, and some DHAs were studying the possibility of direct entry midwifery training. Some of these investigations were completed during the project and caused a change of policy, one way or another. A few resulted in recommendations to run direct entry midwifery courses, and one district found they would be unable to afford such a programme. Second, the DHSS recommendation that each region should have a least one such course (in a letter to do with nursing recruitment, 7 August 1987) caused certain health authorities to reconsider a neutral or negative stance. Finally, as people became aware of the University of Surrey study, many deferred a decision until the results of the study became available.

INFLUENCING FACTORS

Decisions for or against direct entry midwifery training were usually based on personal experience or opinion – indeed, the same facts were used to 'prove' the case for or against non-nurse midwives. In some cases the RHA, DHA, and school were all in agreement about the desirability of such a programme, but had diametrically opposite ideas about the purpose, content and conduct of a course. In general, the RHAs and DHAs wanted to implement direct entry midwifery training for pragmatic reasons. The most important reason given by RHAs and DHAs was present and/or predicted manpower shortages. There was also the hope that a three year course would be more cost effective than RGN training followed by 18 months training. Tutors and midwife managers in favour, although they saw direct entry as a possible solution to manpower problems, espoused the cause because they felt it would re-establish the special role of the midwife.

Decisions against non-nurse midwifery training were also made on both pragmatic and ideological grounds. The practical factors inhibiting it are the organisation of funding for post basic training, shortage of tutors and lack of information (on supply of candidates, structure of course, acceptable experience and so on). The historical and ideological factors inhibiting the development of non-nurse midwifery training are touched on above. Downes' current

DIRECT ENTRY WILL NOT NECESSARILY SAVE THE MONEY WASTED ON TRAINING THOSE WHO DO NOT PRACTISE. WASTAGE WILL DEPEND ON SELECTION AND ORGANISATION OF TRAINING

study[12] on attitudes to direct entry midwifery should provide interesting detail on the prevalence of the various viewpoints.

The perception of cost effectiveness was a very important factor for most of those making a decision on the implementation of new training. Yet few of the respondents had done detailed costings – partly because this is impossible until decisions on curriculum are made, and partly because many felt they needed guidelines on costings. The study produced a costings guide, which proved effective in trials. This shows both net and yearly costs to the maternity budget, DHA and NHS. The cost of a direct entry course would vary dramatically depending on the amount of service contribution, shared learning, and organisation of training. Direct entry will not necessarily save the money wasted on training those who do not practice. Wastage will depend on selection and organisation of training. If the selection procedures and learning conditions are similar to nursing, wastage during training will be high. If working conditions on qualification are unchanged, qualified wastage among single qualified midwives will be as high as among their RGN, RM colleagues – they may not return to nursing, but many other careers are still open to them.

The University of Surrey/ENB study showed that although there was theoretical support for non-nurse midwifery training, few centres are taking any positive steps towards implementing such courses. Most areas are 'on the shore', waiting for someone else to 'try the weather' or for some incentive to 'take the plunge'.

Positive action must be taken if the midwifery professioon really wants direct entry midwifery to succeed. Whether this action is taken by the ENB, and UKCC, DHSS and HAs, RCM, ARM, MIDIRs, NCT, and AIMS, depends on resources available and the role each of these wishes to play. More information and support should be available to those considering the direct entry option. This could be done by newsletters, support groups, study days, or increased advice from statutory and professional bodies. Independent evaluation of existing and new courses would provide valuable lessons. The midwife's role and the possibility of direct entry training should be more widely publicised. The organisation of funding for such training needs to be restructured. A coherent national or regional strategy for all midwifery training needs to be developed.

Part two discusses the potential candidates and the learning environment. **NT**

For information on the availability of the full report of the study, Direct entry: A preparation of midwifery practice, contact the ENB.

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In the second of their reports on the development of direct entry midwifery courses, Nancy Radford and Anne Thompson look at some of the issues that should be considered by those implementing such courses

CHOOSING THE DESIGN

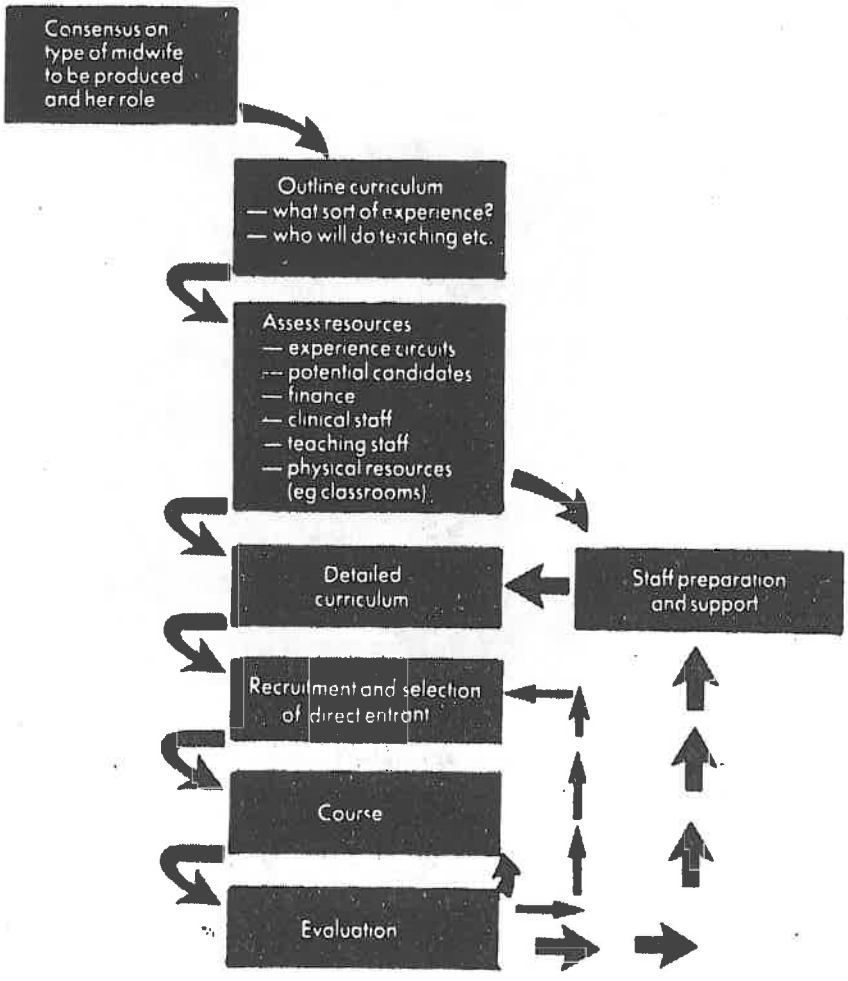
ALMOST important issue, and one on which there is little consensus, is the role of the qualified midwife. All involved midwifery and general managers, tutors, and so on should be in agreement on why they want to implement direct entry and the ideal and the role the midwife will perform once qualified.

Is direct entry midwifery being considered as an answer to recruitment or retention problems, a cost saving exercise, or as a radical rethink of how a midwife should be prepared for practice? Should the midwife work under the guidance of doctors or as 'obstetric nurses' (as appears to be the case in many areas[1,2]. Or should she be an independent practitioner? These were among the questions addressed by the ENB study, which was carried out by the University of Surrey.

The reasons for implementing non-nurse midwifery training will have implications for areas such as the status of the single qualified midwife, curriculum, recruitment, selection and financing. For instance, if the single qualified midwife's training is similar to that of the RGN plus RM training, but cheaper and shorter, the status of the former will be lower than the latter. A training which costs less may often be seen as being worth less. A completely different specialist education/training would be more likely to carry equivalent or superior status.

The course curriculum is a vital issue, which needs to be considered at an early stage, as it will affect the feasibility and cost of the project. What sort of experience and knowledge base do the students need? The accurate identification of the role of the qualified practitioner is an essential pre-requisite for any curriculum design. The amount and type of 'general nursing' experience needed will depend on the role the midwife will play on qualification. Curriculum planners will need to be imaginative and resourceful in seeking out appropriate placements in areas where available experience is limited. One also needs to consider the desirability/feasibility of shared learning with other

Table 1. Stages in considering direct entry



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professions.

How will the students be supported and supervised? The national survey and the interviews demonstrated widespread concern about adequate levels of supervision and support for direct entrant student midwives. Inadequate support for a student without the customary knowledge base can place her in embarrassing or even dangerous situations. Current initiatives, such as a mentor system of student-to-midwife attachment and the team approach to the delivery of care, in theory hold out hope of better support and teaching opportunities. Staff attitudes will influence the effectiveness of these methods in practice.

Resources will have to be assessed — the supply and abilities of tutors, staffing levels, classroom and residential accommodation, number of sites, availability of experience (maternity and other), possibility of collaboration, and sources of finance.

Development of a completely new curriculum will put an additional strain on midwifery tutors, but will also act as a stimulant. Several midwife tutors expressed delight at the thought of a 'clean slate' and were glad that 'we won't have to spend our time debriefing them'. (Comments from interviews).

SEVERAL MIDWIFE TUTORS EXPRESSED DELIGHT AT THE THOUGHT OF A 'CLEAN SLATE' AND WERE GLAD THAT 'WE WONT HAVE TO SPEND OUR TIME DEBRIEFING THEM'

Shortages of staff had held back the development of direct entry in some areas, because it was felt impossible to provide an adequate level of support and supervision in the clinical areas. Because students will be in the midwifery school for twice as long, additional classroom and residential accommodation may be required.

The shortage of experience, accommodation and tutors has led to moves to rationalise midwifery training to make better use of existing resources. A viable direct entry project requires more facilities than a small midwifery school can normally provide. Co-operation and amalgamation would change this situation.

The study covers these areas in detail and provides guidelines on costing. Current funding for midwifery training, whether post-registration or direct entry, comes from the district health authority (DHA) budget, whereas part of the cost of RGN training is centrally funded, so the 18-months course seems at present a more attractive financial proposition for the DHAs. The implementation of Project 2000 and/or changes in the funding of midwifery training could make the direct entry midwifery option more financially attractive.

A survey of potential candidates was carried out as part of the study, and though this provided only a partial picture of the supply of candidates, the exercise as a whole was of great value. First, it showed the difficulty in finding concrete evidence of demand, and highlighted the need for detailed records of enquiries. Few schools had kept any records of enquiries about direct entry midwifery training. Those which had, only recorded the number of enquiries, without any details of the individual enquiring.

The impression one received from the literature and some interviews was of enormous numbers of enquiries from very suitable people. This was difficult to substantiate. From the results of the survey, it is clear that characteristics of respondents varied greatly, and that certain of these characteristics, such as age and dependants influenced the type of course desired (those with dependants tended to prefer a part-time course and were less willing to relocate or travel). Respondents did not all fit into the popular stereotype of mature women with children, and courses designed for such candidates may not be appropriate in all localities.

Lack of awareness of the role and responsibilites of a midwife was also demonstrated. Many respondents seemed unaware that midwives look after women throughout pregnancy, childbirth and the postnatal period. The classic example of this were the 8% who gave some variant of 'I like babies' as their reason for entering midwifery. There must be greater understanding of the midwife's role and conditions of employment, otherwise, some potentially suitable people may never apply, and/or unsuitable ones may take up training. If trainees' expectations are in conflict with reality, there will be a high wastage rate during training.

The survey illustrated that some enquiries about a career in midwifery came from people who would not be able to cope with the training requirements and working conditions, either because of immaturity, intellectual capacity or a multiplicity of other commitments.

To ensure the success of a direct entry midwifery course, there must be a clear idea of the characteristics required in a student midwife, an active recruitment campaign to attract people with these traits, and an effective method of selection. Flexibility in organising of education and working conditions will also play a part in reducing wastage.

Commitment and co-operation between education and service is needed and a willingness to spend time in staff preparation. Some staff will have negative attitudes towards direct entrants, others will have difficulty coping with the students who lack experience in the medical field, but who were perhaps mature, articulate, and experienced in other fields.

There is some evidence from schools with experience of direct entrants that the fresh, questioning approach of the unconditioned students may appear a threat to a well established system, as well as to individual members of staff. Tutors and managers will need clear strategies for the introduction of new ideas, new practices and new people if anxieties are to be calmed and the whole project welcomed with any enthusiasm.

NT

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● For information on the availability of the full report of the study, *Direct Entry: A preparation of midwifery practice*, contact the English National Board.

● Part 1 appeared in last week's issue

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Copies of this study are available from ENB Resource and Careers Services, Chantrey House, 798 Chesterfield Road, Sheffield S8 0SJ. Price £10.

Direct entry: a preparation for midwifery practice

Nancy Radford and Anne Thompson,

University of Surrey, Guildford, England.

Conclusions and Recommendations

1. Introduction

One of the most common misconceptions which the researchers had to tackle was about the purpose of this research. Many people thought that the project would result in a judgement on direct entry midwifery. This was not the remit of the researchers. A decision in favour of direct entry had already been taken by the ENB, and the researchers were asked to assess the factors affecting implementation of that decision.

This study had four main goals:

1. To describe the national situation regarding direct entry midwifery training.
2. To discover the factors inhibiting development of such programmes.
3. To advise on issues which should be considered by those contemplating this option.
4. To recommend ways in which the establishment of non-nursing midwifery training could be facilitated.

The report covers all aspects of direct entry training, and readers may not want to read it straight through. It was written to be used by a variety of people for different purposes. The chapters on each aspect can be read either in isolation, or as part of the whole. The report is structured to enable readers to draw from it what they wish. This chapter will first summarise the national picture, then highlight the major influencing factors, recapitulate some of the most important issues, and finally set out some recommendations for encouraging the growth of the non-nurse component in midwifery. The authors wish to stress that for the full picture, the whole report should be read, and that the following chapter is only a brief recapitulation of some of the results of the study.

2. The national picture

The excellent response rate to the survey and co-operation of schools, districts and regions ensured that a comprehensive national picture was gained. In general, there was a great deal of support expressed for the ideal of direct entry midwifery training, but there seemed to be little agreement as to who should be recruited for such training, what form the training should take, the curriculum, the appropriate environment, etc. etc. As Chapter 8 points out, the RHA, DHA, and school may all be in agreement about the desirability of direct entry, but each have diametrically opposite ideas about purpose, content, and conduct of such a course. Most decisions for or against direct entry were based on personal experience or opinion - indeed the same facts were used to "prove" the case for or against non-nurse training. There are few centres taking any positive steps toward implementing such courses. Most areas are "on the shore", waiting for someone else "to try the water", or for some incentive. The ENB was expected to provide the initial stimulus and ongoing support. (Chapters 3,5,6 and 8)

The survey of potential applicants indicated that there are people interested in a midwifery, rather than a nursing, career. It demonstrated the need for investigating possible recruitment pools, and the necessity of considering changes in selection procedures and organisation of training. (Chapter 4-6)

3 Influencing factors

The factors inhibiting development of direct entry midwifery training, like those encouraging it, are pragmatic, historical, and ideological. The major pragmatic reason encouraging the implementation of such programmes is present and/or predicted manpower problems. The practical factors inhibiting it are organisation of funding, shortage of tutors, and lack of information (on the supply of candidates, structure and organisation of course etc.). Any new project will involve more effort and cost initially.

The historical background and ideological issues are complex. On the one hand there was the gradual erosion of the status of the direct entrant and the change from the practice of midwifery as a separate profession to "a branch of intensive care nursing". On the other hand, there is the history of the midwife as a practitioner in her own right, and the current popularity of "de-medicalising" childbirth. Arguments about how a person should be trained are based on assumptions and beliefs about what skills and knowledge the qualified person needs and should have, which in turn depends on her role. Those who see the midwifery as a "separate tree" feel there is a need for a distinct and special training. There is often a belief that training a "different sort" of midwife will improve and change the delivery of care and the actual role. Some feel that nurse training is actually undesirable as a preparation for midwifery, others that the present role of the midwife requires her to have nursing knowledge, and that nursing training is an important foundation for becoming a midwife. (Chapter 2-6,8).

4. Issues to consider

The issues which must be considered by schools, districts and regions contemplating the direct entry midwifery option are listed below as a series of questions with a brief explanation. The chapters dealing more fully with the issues are indicated in parentheses.

4.1 What sort of midwife will be needed? What should be her role?

The most important issue, and one which has not often been adequately addressed is agreement on the end product. All involved (eg. midwifery and general managers, tutors, etc.) should be in agreement on why they want to implement direct entry, and the ideal and actual role of the midwife (whichever route is used to produce her). Should the midwife work in the same service role as present, but be produced at less cost and lower wastage rates? Or she be someone quite different (eg. independent practitioner)? The type of midwife required will have implications for areas such as the status of the single qualified midwife, curriculum, recruitment, selection, and financing. For example, if the first option is chosen, it is likely that the single qualified midwife will have a lower status than her dual qualified colleague, for her training would be along similar lines, but shorter. A completely different specialist training would be more likely to carry equivalent status. The implications for curriculum are obvious, and it is clear that decisions about the end product affect the choice of raw material and the final cost. Studies (Robinson et al, Garcia et al) have been done into what a midwife's actual role is at this time, but not what it should or could be. This is a decision which the profession must make. The report illustrates the variety of opinion within the profession on the sort of midwife who should be produced and the implications of this decision. (Chapters 2,4,5,6,and 8).

4.2 What sort of training will be needed?

The course curriculum is a vital issue, which needs to be considered at an early stage, as it will affect the feasibility and cost of the project. What sort of experience and knowledge base do the students need? How will the students be supported and supervised? The study explored these and related issues. (Chapter 5 and 6).

4.3 What resources will be required? What is available?

The resources required should be compared to those available

- human, physical, and financial. The report highlights the areas which should be considered, eg. as supply and qualification of tutors, adequate staffing levels for clinical support and supervision, classroom and residential accommodation, number of sites, availability of collaboration with other institutions and sources of finance. (Chapters 4-7). Appendix 6 provides a formula for estimating the cost of proposed and current courses.

4.4 Who should be recruited? Is there an adequate recruitment pool?

The type of midwife desired and course content will naturally affect the type of trainee sought. The research indicated that the size and composition of the recruitment pool will need to be taken into consideration when designing a course. This may require changes in service delivery or educational organization, and the effects of these on the quality of care needed to be evaluated.

The report suggests ways in which the local and national supply of potential candidates can be assessed and the characteristics of this group determined. It highlights why it will be necessary to devise more active recruitment campaigns and more rigorous selection procedures, and suggests ways to do this. (Chapters 4 and 5, Appendix 7).

4.5 What are staff attitudes to direct entry?

The findings of the study indicated that the level of commitment to direct entry midwifery training will have a marked effect on the success of the project. Both managers and tutors must be convinced of its value, and prepared to spend time in staff preparation to ensure that all are ready to give direct entrants "a fair chance". (Chapter 6, and end of Chapter 3).

5. Recommendations

Positive action must be taken if the development of direct entry training is to be accelerated.

5.1 Co-ordination

A liaison group or task force representative of all bodies concerned should be given the responsibility for determining the most effective way forward for direct entry midwifery training coordinating initiatives and maintaining the impetus. (Chapters 1-8)

5.2 Support

Greater support should be given to those considering the implementation of direct entry courses. (Chapters 3,5,6, and 8)

a) An organised link should be formed between all those considering or planning a course as well as those who attempted to implement a course and did not succeed.

b) A series of study days should be run on course implementation eg. selection, curriculum , finance.

c) Additional resources should be allocated to enable the midwifery education officers to help provide the extra support which direct entry midwifery projects require.

5.3 Information

Information on all aspects of direct entry (eg. potential candidates, costing, curriculum) should be easily available from a central source. (Chapters 3-8)

5.4 Research

a) Evaluation of existing and new courses should be carried out. An independent body and the findings made widely available. (Chapters 3 and 5)

b) Each area considering a direct entry project should carry out a local feasibility study. (Chapters 4-7, Appendix 6)

5.5 Communication

Lines of communication between regions, districts and schools should be improved, as should those between them and the statutory bodies. (Chapters 3,5,6, and 8)

a) The ENB should clarify its role in the changing education environment.

b) Each region should appoint midwifery advisers to coordinate initiatives and to liaise between schools, districts, region and the statutory bodies.

5.6 Publicity

The role of the midwife and the opportunity of direct entry training should be more widely publicised.

5.7 Funding

Further research should be carried out to identify the most appropriate and effective organization of funding for midwifery education.

5.8 Rationalisation

To ensure a sound base for the development of new courses, rationalisation of the structure and provision of midwifery education is essential. (Chapters 5-7)

5.9 Strategy

The agency responsible for strategic planning should be clearly identified, and should control funding. (Chapters 3,5 and 8)

5.10 Statistics

Statistics on potential candidates for direct entry midwifery training should be gathered nationally in a standard format.

Aspects of Education

Training for Midwifery in the 1980s

By Lorna Cowan, BA, RGN
Student midwife

Impressions of a student midwife.

Improving the training of student midwives may be one way of safeguarding the future of the profession.

According to the Code of Practice[1] accepted by the International Federation of Gynaecologists and Obstetricians the midwife should be able to carry out the following duties subsequent to her midwifery training:

'She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and 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 patients, 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 practice in hospitals, clinics, health units, domiciliary conditions or in any other service.'

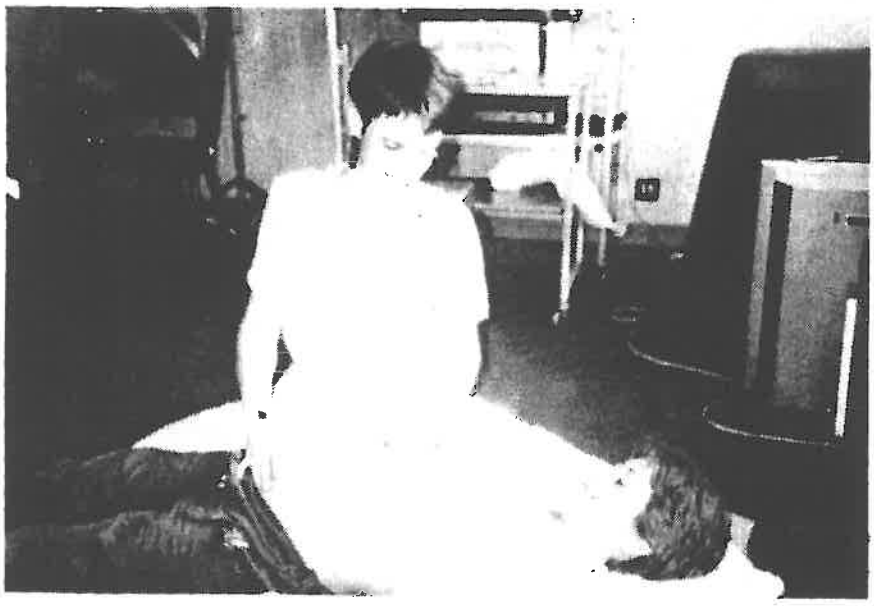
During my training in a large London teaching hospital I have found that most midwives give fragmented care and rarely fully undertake any of the above responsibilities.

In the community the midwives' role has been taken over by General Practitioners or Health Visitors. In consultant units the majority of midwives' work has been eroded by obstetricians: directly or indirectly by unit policies.

The increased use of technology in these units can also undermine, rather than enhance, the skills of the midwife.

I would suggest that this insidious diminution of the midwives role results in parturient women receiving unsatisfactory care and could eventually eradicate midwives as described in the definition above.

It would appear that the 80's are a time when the midwifery profession must look for ways to safeguard its future. Improving the training of student midwives may be one way of doing this and certain aspects of the training can be considered.



Selection of candidates

The majority of student midwives come from a background of general nursing. Robinson (1986)[2] found that only 16.2 per cent of newly qualified midwives in her study were 'intending to make a career in midwifery' before undertaking their 18-months training. This increased to only 24 per cent after qualifying although 85 per cent of the sample expressed some intention to practice. Many student midwives remain orientated towards general nursing and 43.2 per cent gave 'I find more job satisfaction in general nursing' as their reason for not making a career in midwifery in Robinson's study. This can have a detrimental effect on their practice as midwives, and can result in some midwives feeling happiest when looking after ill women, such as abnormal cases and post-caesarian section women.

If the midwifery profession is to survive it needs to promote midwifery training as the beginning of a separate career and not as a post-basic course to general nursing. Midwives require a different approach to general nurses: being able to establish a relationship with a healthy woman; giving education and advice without undermining the woman's independence; being

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able to wait patiently during labour and to be able to act on, and be responsible for, her own decision making are some examples.

There are problems with recruiting midwives from the nursing sector particularly as a reference from the candidate's present nursing officer is often required. If we accept the fact that different qualities are beneficial to a midwife than a nurse, it may follow that nurses wanting to be midwives are dissatisfied with their present work. In which case the long waiting lists for places at midwifery training schools, sometimes as much as two years, may be very off-putting.

By this time these women may have left nursing, or may be seen as 'bad' nurses due to their frustration or outspokenness making references difficult. Even interviewing candidates may not distinguish those really wanting to practice as midwives rather than enhance their nursing career, as preparation for interviews is commonplace and this includes reasons for wanting to make a career in midwifery.

The Report of the Commission of Nurse Education[3] supported the concept of Direct Entry Programmes for midwifery training. However, these appear to remain neglected. If more courses were available the profession could attract women who intended to fulfill the accepted role of a midwife. These women may have more appropriate attitudes to parturient women as they have not looked after ill patients, which often results in a disease orientated approach.

Academic aspects

Midwives have had their own body of knowledge throughout history. During this last century the knowledge of the midwife has greatly increased with the enormous development of obstetrics, and other related sciences such as microbiology, embryology, pharmacology and the use of technology.

The syllabus and training of midwives has reflected these changes and the requirements are detailed in the Handbook of Midwives Rules[4]. However, the way in which the course is presented can vary enormously between different tutors and training institutions.

I feel that the emphasis appears to be on rote learning of a large amount of information, often with a bias towards the obstetric viewpoint. If midwives want to be seen as professionals in their own right they should clarify their own particular body of knowledge which should be research based where possible.

Research into human behaviour, feelings and reactions is notoriously difficult and is often inconclusive, however, it may provide some basis for midwifery practice. Many midwives appear frightened or dismissive of research, which is a pity because the profession would certainly be much stronger if all midwives had a working knowledge of it.

On the whole, lectures from doctors, whether paediatricians, obstetricians, genito-urinary specialists or psychiatrists, were based on theories and research. However, midwifery practice was often stated and justified because 'It's the way we do it here' – especially at ward level. Perhaps having a project on a certain topic as a compulsory part of the training would at least ensure that student midwives became familiar with research techniques and make full use of library facilities. A discussion of this work could form part of the final oral examination.

Class discussions formed a valuable part of my learning experience and may also promote more articulate midwives. This is important if a beneficial relationship between obstetricians and midwife is to develop.

I feel that the midwifery training could be broader based encompassing some phychology, social sciences, philosophies which concern women and childbirth and holistic approaches to medicine. The final midwifery examination papers would need to include questions of a more discussive nature in addition to those at present which are orientated towards midwifery procedures. This may result in the Advanced Diploma in Midwifery becoming obsolete.

Clinical aspects

The English National Board lays down detailed guidelines of the extensive experience a student midwife must gain during her training. The clinical aspect of the student midwives training is very important and again varies greatly between training institutions depending on the type of experience they can offer in their area. The development of my clinical skills resulted primarily from working on an individual basis with experienced midwives, particularly in the community.

Unfortunately there does exist a complaint amongst many student midwives that their previous nursing experience, where it is applicable to midwifery, is often berated: I call it the 'Can you take a blood pressure' syndrome? This is demoralising and may contribute to the fear of taking full responsibility for a woman's care upon qualifying.

Clinical experience is often fragmentary with post-natal care one week and labour ward the next. This can result in student midwives feeling confident in skills related to specific areas such as ante-natal abdominal examinations or care of the mother during labour, and this was reflected in Robinsons study in 1976.

The overall view of a woman in the context of her family and own environment in pregnancy, labour and puerperium can only be seen with home confinements. In Robinsons study this was the one area where the majority of newly qualified midwives lacked confidence with 60 per cent responding that they felt 'less than adequately prepared' to care for mothers during a home confinement. Some student midwives have no experience of a home confinement and perhaps this should be a compulsory part of training.

As the clinical skills of the midwife are so important I would suggest that the satisfactory continuous assessment of student midwives clinical work should be a statutory requirement before registration.

The future

In the future I hope that the training will be broader-based and be seen more as an education than a training. Perhaps even a degree in midwifery may be possible in the same way that we have a degree in nursing now.

A holistic approach towards parturient women is more satisfying for the midwife and her clients. Various moves are being made towards this with the introduction of consultant teams (where a group of midwives work under one particular consultant) in some units.

Research is being done into the concept of midwives teams which holds exciting possibilities for the future particularly if they could be incorporated into the midwifery training.

Ultimately I hope that midwives will be able to fulfill as much as possible the definition given at the beginning of the article.

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