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DIRECT-ENTRY MIDWIVES PROVIDE POSITIVE BENEFITS FOR PATIENTS

Midwives at the turn of the century were midwives. That is to say, they had set their hearts on working in the field of pregnancy and childbirth, and their entire training was geared to that end.

Today, only 3 per cent of our midwives have received such specific training without first learning how to be a general nurse. Yet a direct-entry system of training for midwives presents several positive benefits.

The direct-entry midwife has not been trained to view pregnant women as sick and, since the majority of women in childbirth are indeed perfectly healthy, her attitude towards them is likely to be an appropriate and welcome one. She is also far more likely to stay longer in the job – it is, after all, exactly what she chose to do, whereas the varied career options open to a general nurse allow for a change of heart at any time.

This longer-term career outlook by the direct-entry midwife is particularly relevant today, since the trend towards care in the community is a trend in which midwives have a big part to play.

In addition to all these advantages the direct-entry midwife, while passing exactly the same examination as the midwife who is a trained nurse first, is cheaper to train: a registered general nurse will spend three years on her nurse education, followed by a further 18 months to qualify as a midwife. But the direct-entry midwife is qualified after a three-year training, as laid down by EC regulations, and UKCC rules.

In spite of all these benefits, Britain has only one centre for training direct-entry midwives, based at Derby City Hospital and producing just eight qualified midwives a year.

The person in charge of this unique scheme is Miss Marian Young, director of midwifery education for South Derbyshire health authority. Marian, as she prefers to be called, joined the scheme nearly 11 years ago, having worked previously in the Army, first as a midwifery sister and then as an obstetric teacher to student nurses.

The direct-entry system started in Derby 50 years ago but, until the implementation of the EC midwives directives in 1981, it was only a two-year course. When Marian joined the scheme, there was a considerable stigma attached to being a direct-entry midwife, promoted particularly by the trained nurses. And indeed, that stigma remains rife today.

Marian says: "I can understand why people might have thought them different in the old days – the two-year course certainly wasn't as good and the students did tend to be much more mature, and often didn't stay in service very long or get promoted once they had qualified."

But today, Marian's students all go on to get jobs and promotions, and their most common observation is that fellow nurses continue to put down direct-entry midwives while telling them: "But you're different".

They are indeed different from midwives at the turn of the century, but no different from nurse-midwives today. Their training, whilst obviously excluding such subjects as geriatrics and orthopaedics, is intended to equip them for every eventuality. They learn about diseases affecting child-bearing women, they gain medical and surgical experience and go to the gynaecological wards, they study paediatrics and they work in acute admissions to give them the knowledge to recognise conditions like a diabetic crisis, or a pulmonary embolism, which might affect pregnant women.

One of Marian's former direct-entry students, Sue Downe, still works at Derby City Hospital having qualified in November 1985. She gained a linguistics degree before deciding to become a midwife and was told about the Derby course when she applied to be a nurse and explained to the interviewers that midwifery was her goal.

Ms Downe, 28, agrees with Marian that the direct-entry midwife's view of her patient as healthy is a beneficial one. She also says: "I think we tend to have more faith in the process of childbirth. A lot of midwifery is intuition, and maybe we trust that more than the others."

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Direct Entry Midwifery

(From Homebirth Australia Newsletter #14 Spring '87)

CATHERINE WILLIS

In 1981 the National Midwives Association of Australia adopted the following definition of a midwife at their Annual General Meeting:

"A midwife is a person who is trained to practise midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognise the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor and carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domiciliary service. In any of these situations she has an important task in health education within the family and the community. In some countries her work extends into the fields of gynaecology, family planning and child care."

This definition outlines the skills and areas of service of a midwife and can therefore be regarded as the basic model upon which any midwifery education programme should be based. It is reasonable to assume that a comprehensive programme would prepare the student to perform the required skills and prepare a midwife to work in the areas outlined. A Direct Entry Midwifery (DEM) programme is one attempt to rationalise the education of a midwife with the accepted definition.

The proposal of a Direct Entry course for midwifery is based on the following basic principles:

* The parturient woman is the central person in the process of care;
* All women should have continuity of care whether they are low or high risk;
* Women should have the right and responsibility to choose whatever birthplace and attendants they believe will best suit their needs;
* Services provided by the midwife should be accountable to the consumer;
* The preparation of the midwife should be specifically to enable her to fulfil her practitioner's role as stated in the definition set out above;
* The criteria for selection and curriculum design must remain the responsibility of midwives.

Prerequisite - Selection Criteria

DEM recognises the difficulty inherent in changing orientation from therapeutic care to a promotion of health and wellness. The criteria for selection should take account of such factors as reasons for undertaking the course and motivation to practise in the profession of midwifery. In Willis' study the issue of prerequisites for a Direct Entry course was investigated but there was no consensus as to the appropriateness of either academic levels like the Higher School Certificate, or tertiary qualification. Rather than academic achievements, criteria that were considered as desirable in the selection of student midwives were: previous childbearing experience; a genuine desire to practise midwifery; a caring and empathetic nature; experience working with babies and mothers; motherhood; positive attitude to health, healing, birth and motherhood (Willis, in print).

If a DEM programme was implemented at a College where academic achievement was the traditional method of selection and it was considered appropriate to determine such a level, either the Higher School Certificate or equivalent result could be used, or the results of a specially designed entrance examination could be used.

There are arguments for imposing an age barrier on students. It is thought that an adolescent, newly graduated from high school would be unlikely to have the necessary life experiences or maturity to allow them to function effectively as midwifery students or to understand the process of birth that they are expected to study. It appears that there are three broad categories of women interested in a DEM programme:

* Women who want to be midwives but find the present method of training unacceptable;
* Women who are currently working as lay midwives and want a method to have their experience and knowledge assessed and recognised;
* Women who are working in other areas of the healthcare system (eg physiotherapists or childbirth educators) who are presently interested in extending their services to midwifery (Willis, in print).

In a recent study to establish if there was a need and a demand for a DEM course, interest was expressed by a number of women for such a course. In response to the question "If a 3-year full-time (or equivalent part-time) DEM course was established would you be interested in enrolling in the course?", the following results were obtained:

TABLE 1

Number of Respondents	Interest	Enrolling Now	Enrolling in Future
85	Fulltime	28	57
133	Parttime	56	77
96	Either (with credit)	42	54

Of the 14 respondents who indicated they were lay midwives, 11 expressed an interest in some form of DEM course (Willis, in print). The DEM course could accommodate lay midwives by providing an opportunity by which these midwives who have been previously practising midwifery unregistered can fulfil the necessary educational requirements and thus gain registration. The opportunity to recognise the skills and knowledge of this group of midwives will then be available. This is not possible under the present system.

Curriculum

The increase in information and skills, particularly in the area of birth technology has led midwives nationally and internationally to question the length and content of their courses.

In the United Kingdom training for postgraduate nurses in midwifery has been extended to 18 months to keep level with the standards of the rest of the EEC. In Europe the training of midwives is almost solely by 3-year DEM courses. In most of these courses there is no advanced standing given to those who already have nursing qualifications. To gain registration in the EEC, Australian registered midwives must undertake further training to gain equivalency in qualifications. Australian midwives must surely question the adequacy of their courses if they are not accepted internationally. The introduction of a DEM programme would address this problem.

A Direct Entry course in midwifery would be offered as a 3-year full-time programme incorporating skills and knowledge in the following areas: (a) Biological Sciences; (b) Social Sciences; (c) Behavioural Sciences; (d) Natural Healing; (e) Medical Science - Preventative Medicine; (f) Medical Science - Patho-physiology. The clinical training for the DEM course will incorporate the principles of continuity of care in the following situations: (a) hospitals; (b) birth centres; (c) community health units; (d) domiciliary service. The course will also have specific content to allow the development of the following skills in the individual: (a) Stress Management; (b) Communication Skills; (c) Counselling Skills; (d) Management Skills; (e) Assertiveness Training; (f) Research and Data Collection Skills.

Implementation of DEM

Implementation of a DEM programme could take several directions. One possibility is that a curriculum could be developed and the areas of midwifery training that overlap nursing training could be determined. A course could then be developed where an amount of time would be spent combined in a common course with nursing. This is a suggestion planned for midwifery education in the UK. Such an option it is argued would give the advantage of gaining credibility with institutions of higher education. It would give Direct Entrants an easy route into general nursing and nursing practitioners could still do a course in midwifery. It would give access to already existing resources in education. However such a programme does not risk confronting the issue of the relationship between nursing and midwifery and in fact would tie midwifery to nursing even more than it is already by preventing midwifery becoming a separately identifiable profession educationally.

A second option educationally is to develop a DEM programme independent of nursing. Such a programme would recognise that there are skills from many areas that contribute to skills needed for midwifery. It would have to establish its own academic credibility and deal with the issues of access to resources, career prospects, career retention and recruitment. However this course would clarify the issue of the relationship between nurisng and midwifery. It would be a statement of the independence of the profession and would set the direction for the future of midwifery.

In Australia it could reasonably be assumed that providing there was a common method of assessment of skills and knowledge, the routes by which students gain their theoretical knowledge and clinical experience could be varied. This is particularly relevant in a country where there is such varied distributions of populations and also varied demand for midwifery skills. Hospital-based programmes could continue to allow nurses the opportunity to train as midwives. Colleges of Advanced Education could develop midwifery programmes according to the local need and demand. This would include DEM programmes. An external studies programme could also be developed for the theoretical component of the course to allow women who would otherwise be excluded because of their geographic location or particular situation to participate.

It is also necessary to consider the possibility of varied training methods because there are so many lay midwives practising in Australia for whom a full-time 3-year course by Direct Entry is just as inaccessible as the present nurse/midwifery programmes are unacceptable.

Provided there was a general set of competencies which would characterise the level of performance required for registration - eg a satisfactory standard of theoretical knowledge, observation of a number of births, assistance at births and being responsible for a number of births - the standards of midwifery training could be monitored.

Cost of Direct Entry Midwifery

A comprehensive estimate of the cost of implementing DEM is not yet available. However the present system of educating midwives is wasteful of resources and inefficient in its ability to meet the demand for midwives with an estimated loss of 50% of new graduates (Barclay 1981). Such a system is not cost effective. The proposed DEM programme would have women highly motivated in the profession after graduating. Studies in England indicate a high retention rate within the profession of Direct Entrants. Changing the selection criteria alone would seem to make training more cost efficient than the system in use at the moment. Further, because graduates are highly motivated to practise they are more likely to stay as practising midwives and would contribute to solving the chronic shortage of midwives at present being experienced in maternity hospitals in Australia. This would offset whatever extra costs were incurred in a longer training period.

CATHERINE WILLIS

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Barclay L (1981), "How is the midwife's training and practice defined in policies and regulations in Australia today?", Health Policy, Vol 5 1981, pp 111-132.

Willis C, in print.

FOR MIDWIVES THERE ARE GOOD REASONS TO EMPHASISE THE DIFFERENCES BETWEEN THE TWO PROFESSIONS

Nursing and midwifery look set to part company. The partnership by which the vast majority of midwives first qualify as nurses is likely to loosen over the next 10 to 15 years. In the long term, most midwives will not be nurses.

Last week's announcement that the department of health will fund more direct entry coures for midwifery coincided with the publication of a report from the Royal College of Midwives on the future role and education of the midwife in the UK[1]. The RCM not only argues for separate training, it also omits any reference to nursing as a route towards qualification. Indeed, in a document that is rather longer on advocacy than analysis, there is just one mention of nursing and that was only included to point out differences between it and midwifery.

This enthusiasm on the part of midwives to distance themselves from nursing may seem distasteful to some nurses. After all, every one of the working group that produced the RCM report is a nurse as well as a midwife. Yet this route to becoming a midwife is neither applauded nor condemned; instead it is ignored as if it does not exist and has no future.

Yet for midwives there are good reasons to emphasise the differences between the two professions. In recent weeks it has become all too apparent that the midwife's right to practise is under threat. Some unit policies have set out specific clinical responses which, in effect, undermine the midwife's ability to exercise her clinical judgement. Given the onward march of technology and the medicalisation of childbirth which has already threatened their independence, it is hardly surprising that midwives are anxious to defihe professional boundaries and distance themselves from nurses and doctors alike. The last thing they want is to become obstetric nurses in the American mould, and who can blame them?

However, it is ironic that nursing and midwifery should drift apart at a time when nursing reformers are emphasising just those qualities that midwives say are so essential to their work. Nurse education is planning to place more emphasis on health, to become more holistic and place greater importance on the nurse as an autonomous and accountable practitioner.

But the departure of midwifery may not be all bad news for nursing — presumably nurses will continue to have the opportunity to undertake post-basic courses in midwifery and enrich both professions as a result.

The abandonment by the UKCC of the experimental midwifery branch in its final Project 2000 proposals[2] may also allow for some questioning of the health model of care.

If we are honest, then we should admit that the demands on nursing skills will continue to come from the sick, who must remain the profession's top priority. NT

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World Infant Mortality Rates from the *1987 World Population Data Sheet*

Deaths in the first year of life per 1000 live births

1.	Japan	5.5
2.	Iceland	5.7
3.	Finland	6.5
4.	Sweden	6.8
5.	Switzerland	6.9
6.	Hong Kong	7.5
7.-8.	Canada	7.9
7.-8.	Denmark	7.9
9.	Netherlands	8.0
10.	France	8.1
11.	Norway	8.3
12.-13.	Ireland	8.9
12.-13.	Taiwan	8.9
14.	Luxembourg	9.0
15.	Singapore	9.3
16.-17.	Belgium	9.4
16.-17.	United Kingdom	9.4
18.	West Germany	9.5
19.	East Germany	9.6
20.	Australia	9.0
21.-22.	Antigua and Barbuda	10.0
21.-22.	Netherlands Antilles	10.0
23.-24.	Spain	10.5
23.-24.	United States	10.5
25.	New Zealand	10.8
26.	Italy	10.9
27.	Austria	11.2
28.-31.	Brunei	12.0
28.-31.	Cyprus	12.0
28.-31.	Macao	12.0
28.-31.	Reunion	12.0
32.	Israel	12.3

Midwives step out on their own

Growing demand from women for less medical intervention and more control over the birth experience has led Northland midwives to raise their profile.

They are joining a national move to break away from the Nurses' Association and establish a new professional group, the New Zealand College of Midwives, to be launched this weekend in Christchurch.

Northland co-ordinator for the college, Ms Lynley McFarland, said historically midwifery and nursing were separate professions, but with increasing medicalisation of birth the two had become merged.

"When pregnant women were hospitalised and anaesthetics became a common part of the birth process midwives lost their traditional role of birth attendant.

"The medical profession needed nurses rather than midwives to support their approach to birth," she said.

Role confusion had been exacerbated by the requirement for midwives to complete a nursing course before qualifying. However the college would be pushing hard for a direct entry training course for midwives, Ms McFarland said.

Experience overseas was that a greater role for midwives could bring about less medical intervention in birth — and they were also cheaper.

College president Mrs Karen Guilliland said the establishment of the college was one response to women's calls for more control of their births and a return of the traditional midwife.

It would provide a focus which hopefully would stop the erosion of the midwife's role and women's choice, she said.

Non-midwives, or "customers", would be included as active members of the college to help achieve a service which reflects their needs.

"The objectives of the college reflect our commitment to sharing knowledge," Mrs Guilliland said.

Northern Advocate April '89

Midwives go it alone

'MIDWIVES have set up their own professional organisation to break away from what they see as elitism in the medical profession.

After several years planning, the New Zealand College of Midwives was formally launched in Christchurch.

The national president, Mrs Karen Guilliland, said the Cartwright report had made a lot of midwives accept that a separate body was needed.

"The report highlighted how elitist the medical profession has become," she said. "We do not want to eclude women from what is going on."

Mrs Guilliland said the women the college worked for were included as active members.

"We rely on the involvement of other women in order to achieve a profession and health service which reflects their needs. The objectives of the college reflect this commitment to sharing knowledge."

In the past midwives have been represented by the Nurses' Association.

NZ News UK - 17.4.89

Midwives' new baby

An open letter to NZNA members

April 2 marked the official opening of the New Zealand College of Midwives. It also signalled the end of the National Midwives Section.

Midwives and nurses have had a professional "bonding" that dates back to 1969 with the formation of the midwives and obstetric nurses special interest section. At times it was a stormy relationship, but in recent years we believe many nurses have come to acknowledge (if not understand) the differences in our roles.

In 1986 we were delighted at the NZNA acceptance of the World Health Organisation's definition of a midwife and also, two years later, with the support we received from the association for the Midwifery Policy Statement. Collaboration of nurses and midwives also enabled the separate midwifery education courses to eventuate. All of these were milestones for midwifery.

However midwives have also undergone much political and personal development in this time and have come to believe it is essential for us to have our own voice and take on the responsibility for our profession.

We have many major health and welfare issues ahead of us in today's political and economic climate. We need to give our time, energy and commitment to midwifery to ensure New Zealand women have the midwifery service they require. We need a distinctive, obvious place of contact to focus our energies from and towards. We believe the college will provide this.

We also rely on the involvement of other women in order to achieve a profession which reflects their needs. The New Zealand College of Midwives is different from most professional bodies in that we have consumer members represented on regional and national committees. Midwifery is intertwined with women and we are unable to separate ourselves from them — neither do we wish to! It is the women who define our practice and who give us our direction.

We see professionalism equated with expertise and expertise as something to work for and to share. It is therefore appropriate that our constitution allows non-midwives to be active members. We are a professional organisation, consequently the majority of our members will remain individual members of NZNA for their industrial representation. We will continue to encourage midwives to be actively involved at the workplace and many are already doing so.

The decision to have our own professional body was not taken lightly and is the result of many years' discussion among midwives. We believe it is a decision that has not only been shaped by professional growth but also the social context in which we practise.

We hope you will celebrate with us.

New Zealand College of Midwives
PO Box 21-106
Christchurch

NZNA blessing

NZNA offers best wishes to the NZ College of Midwives and will continue to liaise with the new organisation on matters of mutual interest to midwifery and nursing.

As outlined in the above letter NZNA continues to represent all midwives industrially ie in award negotiations, and NZNA members in personal grievance situations, staff-surplus situations and in many professional areas affecting nurses and midwives.

Gay Williams
NZNA Executive Director

NZ Nursing Journal, April 1989