Crossing the boundary – are we losing the plot?

***Monika Boenigk** shares some thoughts on the debate about 'advanced skills' for midwives*

In response to growing pressure from a number of state governments for midwives to take up 'advanced' roles, the College published a discussion paper in the summer issue of this magazine inviting comments from members on the issues. Midwife Monika Boenigk gives food for thought in this response to the discussion paper.

At a conference in Salt Lake City, Utah, a couple of years ago, I came across a trade display where a university advertised for a range of already operational, advanced skills courses for midwives, along the lines canvassed by the options paper published by the ACM in the summer issue of the *Australian Midwifery News*. In particular, they promoted the role of midwife-assistant at caesarean sections, to replace the second doctor at the operating table in order to save hospital costs or make up for shortfalls in under-staffed units – neither of these being woman-centered considerations. So it seems that the current trend here in Australia is a hand-me-down from events in the US.

Where we are

As much as I believe it is important to move forward into uncharted territory and remain flexible in all professional facets of our work, it horrifies me to think that we have not even arrived at first base when it comes to being the kind of midwife that is required to promote and facilitate a holistic approach to childbirth and beyond; namely, being with woman, which is what I always believed to be the essential description of a midwife. There is solid evidence that thorough one-on-one midwifery care that embraces a holistic philosophy rewards us and our clients with excellent outcomes, high satisfaction rates and very low litigation rates.

There was a brief period of progress in this regard in the 1990s when midwifery practitioners, birth centres and shared-care arrangements were well-accepted and well-used elements of obstetric and midwifery care, indeed, they were in the ascendancy. However, towards the end of the 1990s and into the early 2000s we regressed steeply into a climate driven by fear, suspicion and uncertainty. We have only slowly begun to crawl out of that hole over the last few years, thanks to the monumental efforts of a group of dedicated and outspoken leaders of midwifery in this country. We have recently begun to make inroads once more into models of woman-focused care – programs that women deserve and can trust.

I believe that our College and other midwifery administrators already have their hands full ensuring that what the College describe as 'standard skills' are penetrating into, and adopted by, the many bastions of resistance still remaining among today's midwifery professionals. But are we starting to lose focus and grow another head?

Conflict of interest

The expression, 'advanced midwifery skills', connotes a refining, deepening and expansion of already existing skills. When I look at the content of advanced midwifery skills canvassed by the discussion paper, I can see only one topic (counselling skills) that readily strikes me as building on existing knowledge of woman-centered, holistic midwifery care. It is the ability of listening thoughtfully and reading between the lines that enables the midwife to expand her skills on being 'with woman' and her family, and to provide individualised support tailored to each family's situation. The other proposed advanced skills listed indicate to me a crossing of existing or yet-to-be-delineated professional boundaries and represent, moreover, a conflict of interest with what midwives are meant to be doing.

Advanced midwifery skills should only be employed by practitioners with a well-rounded holistic background to ensure the appropriateness of their use. In any other case, health professionals engaged in the application of such skills might need to be given separate career paths and titles, while the holistic midwifery practitioner acts as liaison, coordinator and interpreter between such professionals and the woman/couple. Of course, we could always contemplate scrapping the title 'midwife' and call ourselves something that covers the range of professional skills suggested in the discussion paper, such as 'reproductive attendant', 'childbirth health advocate' or 'midwife-doctor'. But really!

If we maintain the title 'midwife' to describe our professional mission, then any additions to our skills portfolio should directly relate back to that mission. Existing branching-out, such as women's and family health, contraception (including abortion counselling), lactation consulting, baby health, infertility counselling, and adolescent pregnancy care, to name a few, does in my view fit this bill comfortably, as midwifery practitioners caring for couples all the way through pregnancy, birth and beyond touch on some or all of these subjects to varying degrees at different stages of care. I am not so sure, however, about the skills suggested in the discussion paper.

The golden rule of backing up

Let me pick just one example from the 'advanced skills' list and examine it in some detail.

The mind boggles when contemplating how a midwife who has been interactively engaged with a couple through many hours of labour, should then be obliged to see if she can wrench the baby out by forceps just because she has a certificate to do so. All midwives know how much physical effort, skill, experience and concentration this serious intervention sometimes entails, let alone the risk of misfortune and its consequences. Imagine the pressure a midwife would find herself under to succeed while also trying to maintain empathy and connection with a woman who might be most distressed about the turn of events.

Second, since we never know whether an intervention will be successful, it is prudent to follow the golden rule of 'don't attempt what you can't back up'. Imagine doing a lift-out forceps on a baby in distress. The intervention fails to get the baby out. What is the back-up plan? Doing a Kielland rotation or follow through with a caesarean? Who is supposed to pick up from such failed attempts and try to save the situation?

Third, other than performing a number of lift-out forceps on a regular basis, how would a midwife maintain competency with such complex procedures in the long term? How much might all of this

influence the inclination to put salad spoons on a baby's head prematurely (or not, as the case may be)?

And what about professional insurance cover? How would the ability to perform obstetric intervention procedures affect our ability to attract malpractice insurance? It seems to me a whole mountain range would need to be climbed to assure cover for forceps births performed by midwives, when we are already struggling to get up the ridiculous little molehill of obtaining cover for attending normal births that we are trained, certified and experienced to do. Or are we assuming that all 'advanced' midwives will be indemnified by their hospital employers, thus putting yet another nail in the coffin of private midwifery practice?

Creating a void

Most importantly, though, what about the woman?The moment a midwife engages in any potentially complicated obstetric intervention (or any other specialised medico/technical procedure), she vacates her place beside the woman and steps into the role of a (hopefully) cool-headed, focused, technical operator whose energies are totally absorbed by the procedure, its challenges and risks. Who is then going to step into the void? How will midwives continue to explain what is happening, soothe the woman's state of mind or allay her panic, reassure her and her partner, help her with her breathing and any physical adjustments she might need to make, while at the same time trying to pull the baby out by forceps? How will the practitioner facilitate the bonding process once the baby is born when she is busily mopping up the woman's vagina, putting in stitches or trying to stem a resultant bleed? Will we concurrently with the acquisition and practice of those 'new skills' have to design a new profession which will take up the slack? Perhaps a midwife-assistant or enrolled nurse will suffice?

Interestingly, in the recently released, highly regarded Australia–NZ collaborative textbook *Midwifery* which contains just under 900 pages, the subject matter of 'Forceps' is given but half a page. It seems to me that this is clearly a reflection of its place in modern holistic midwifery.

It also concerns me how this split might affect the employment selection process. As we know from other areas of the workplace, in general, the more ticks you have, the higher your chances of landing the job. Are we then going to pressure traditional midwives to venture into 'advanced skills' areas to enhance their job prospects? And while everyone is busily training-up, who is filling the existing positions in a midwifery market already short of midwives?

Crossing the boundary

Consider for a moment the energy, woman-power and time our professional body would have to muster in order to set up, implement and then govern such a monumental shift. Imagine what would be involved with developing *National Advanced Midwifery Practitioner Competency Standards* and a nationally applied tool to judge such competence. Not only would it stretch the capacity of our College to the maximum, but it might seriously affect efforts in other, and I believe more pressing, areas of current midwifery and childbirth concern. There is also the question of who might judge competency. Will we need to enlist obstetricians, ultrasonographers, anaesthetists and emergency doctors to evaluate and certify our performance on an annual basis?

We have already delegated numerous activities inherent in midwifery to professionals of other disciplines such as nutritionists and physiotherapists. Instead of venturing out into other professional territory we would be well-advised to re-claim those skills and activities so that we can once again offer our women well-rounded holistic midwifery care.

I suggest that by engaging in the proposed advanced skills training we are at serious risk of crossing the boundary separating us from other professions: medical doctors, obstetricians, ultrasonographers, pathologists, paediatricians, anaesthetists, neonatal nurses and paramedics. Let's not be surprised at the ensuing turf war.

Misdirected ambitions

From my observations of midwifery in Australian maternity hospitals – as heretical as it might sound to some practitioners – I believe that advanced skills are particularly needed in numerous areas much closer to home. To name just a few:

- basic counselling (including self-awareness);
- assertiveness;
- holistic interactive engagement;
- conducting holistic antenatal classes;
- holistic antenatal care;
- early labour care at home;
- birth at home;
- facilitating normal childbirth;
- supporting upright birthing practices;
- familiarity with upright birthing equipment;
- breathing techniques;
- relaxation techniques;
- in-depth physiological and psychological knowledge about the phases of labour;
- dealing with fear, panic and trauma;
- dealing with physiological *and* psychological 'obstruction' in labour;
- postnatal de-briefing and ongoing support;
- basic competency in dealing with postnatal depression;
- meaningful engagement of the partner;
- creation of a supportive, respectful and reassuring physical, spiritual and emotional birth environment – especially immediately pre-and post-birth;
- peer-review;
- woman-focused care;
- diplomatic inter-disciplinary liaison;
- mentoring of student midwives (our colleagues of tomorrow);
- language used with the couple in our care; and
- awareness and active integration of the social significance of childbirth in the context of the community in which it occurs.

I believe a substantial degree of these advanced skills is desperately needed in all areas currently filled by Australian midwives.

Perhaps if some midwives just don't want to work in any of these currently accessible areas but instead prefer exclusively to perform, say, ultrasound scans in pregnancy, they might wish to consider training as an ultrasonographer. This then gives them half a chance to become really good at that. Otherwise, we might be running a risk of our profession getting a bad name for not doing anything well.

And if the reader thinks that my suggestions of where to focus our energy for skill-advancement are 'old hat' and represent ground long covered by the midwifery profession, then my question to you is: 'Why are the effects nowhere near enough seen, heard, felt and reflected, not only in our statistical childbirth outcomes, not only by our clients, but also in our own professional satisfaction?'

It is all very well to forge into territory that blurs professional boundaries, with the ensuing feather-ruffling, but to do so without both a solid basis in holistic midwifery *and* unity of purpose in our own ranks seems foolhardy. While some midwives might welcome such a move, I for one fail to see the benefits for our profession as a whole or for the families in our care.

Thank you to other members who have also commented on this discussion paper. The College is interested in hearing from members. Email our Professional Officer, Teresa Walsh, with your views at programs@midwives.org.au.