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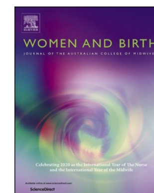
Women and Birth xxx (xxxx) xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth



Review article

The role and scope of contemporary midwifery practice in Australia: A scoping review of the literature

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A R T I C L E I N F O

Keywords:
Australian midwifery practice
Scoping review
Models of care

A B S T R A C T

Problem: Little is known about the breadth of midwifery scope within Australia, and few midwives work to their full scope of practice.
Background: Midwives in Australia are educated and professionally accountable to work in partnership with childbearing women and their families, yet they are currently hindered from practicing within their full scope of practice by contextual influences.
Aims: To perform a scoping review of the literature to map out the role and scope of contemporary midwifery practice in Australia
To identify any key issues that impact upon working within the full scope of midwifery practice in the Australian context
Methods: A scoping review of the literature guided by the Arksey and O'Malley's five-stage methodological framework, and the 'best fit' framework synthesis using the Nursing and Midwifery Board of Australia's Midwifery Standards for Practice.
Findings: Key themes that emerged from the review included *Partnership with women; The professional role of the midwife;* and *Contextual influences upon midwifery practice.* **Discussion**
Tensions were identified between the midwifery scope of practice associated with optimal outcomes for women and babies supported by current evidence and the actual role and scope of most midwives employed in models of care in the current Australian public healthcare system.
Conclusions: There is a mismatch between the operational parameters for midwifery practice in Australia and the evidence-based models of continuity of midwifery carer that are associated with optimal outcomes for childbearing women and babies and the midwives themselves.

Statement of significance

Issue

An impending shortage of midwives is predicted for Australia for age-related and other attrition reasons.

What is already known

Little is known about the breadth of midwifery scope within Australia, and few midwives work to their full scope of practice. Being able to work to the full scope of their role is a key factor in midwives' retention in the maternity care workforce. There is an urgent need to review models of maternity care in Australia to facilitate growth in midwifery continuity of carer, relationship building, and partnership to optimise perinatal health and well-being, and to reduce midwifery burnout.

What this paper adds

This paper provides a contemporary review of midwifery scope of practice in the Australian context. Using the rigor of the 'best fit'

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https://doi.org/10.1016/j.wombi.2022.12.001
Received 23 June 2022; Received in revised form 2 November 2022; Accepted 1 December 2022
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Please cite this article as: Vanessa Watkins, *Women and Birth*, https://doi.org/10.1016/j.wombi.2022.12.001

framework to explore midwifery scope of practice, barriers to Australian midwives working to their scope of practice are discussed in terms of professional and structural challenges.

1. Introduction

In Australia, midwifery scope of practice is defined by the Australian College of Midwives (ACM) [1], based upon the international definition and scope of practice of the midwife agreed by the International Confederation of Midwives (ICM), and within a professional framework of autonomy, partnership, ethics and accountability [1,2]. Midwives in Australia are educated and professionally accountable to work in partnership with childbearing women and their families to provide support, care and advice throughout pregnancy, labour and birth and the postnatal/ neonatal period on the midwife's own responsibility [1]. The professional standards for midwifery practice in the Australian context are regulated by the Nursing and Midwifery Board of Australia (NMBA) under the Health Practitioner Regulation National Law (2009) [3].

Studies have reported that midwives are currently hindered from practicing within their full scope of practice by contextual influences such as fragmented care, medical dominance and the low status of midwifery within organisations, community and inter-professional dynamics [4]. Worryingly, poor workplace culture and role dissatisfaction have been identified as key factors in midwives intention to leave the midwifery workforce [5]. The aim of this study was to perform a comprehensive scoping review of the peer-reviewed published literature to map out the role and scope of contemporary midwifery practice in Australia in terms of the activities and tasks performed and models of maternity care, and to identify any key issues that impact upon working within the full scope of midwifery practice in the Australian context.

2. Methods

A scoping review of the literature was undertaken guided by the Arksey and O'Malley five stage methodological framework [6] (Table 1). Unlike a systematic review and metanalysis, the scoping review methodology facilitates the collation of a "diversity of relevant literature and studies using different methodologies" [5,7]. The scoping review methodology was selected to identify the themes associated with role and scope of contemporary midwifery practice in Australia, to enable identification and mapping of the themes and concepts related to midwifery scope of practice from the evidence-based literature, and to uncover and explore any areas of complexity or controversies or gaps in the literature. The framework of Arksey and O'Malley [6] enabled flexibility to clarify concepts related to the scope of midwifery practice by using exemplars from empirical studies. Comprehensive searches were conducted of key databases, including CINAHL Complete, Medline Complete, APA Psycinfo, and Scopus, followed by a hand-search of key journals and examination of the reference lists of included studies. Studies published in the international literature were included in the search strategy and these were reviewed using the international definition of the midwife [2]. These studies were included to augment the available Australian studies, to provide context and / or further explore identified issues. Publications from midwifery professional and regulatory bodies were also examined and used to provide structure for identification and interpretation of empirical evidence from peer reviewed publications.

Table 1
Stages of the Arksey and O'Malley scoping review framework.

Stage	Process
1	Identifying the research question
2	Identifying relevant studies
3	Study selection
4	Charting the data
5	Collating, summarising, and reporting the results

Note. Source: [6]

Empirical studies and professional documents were critically appraised for inclusion using tools from the Joanna Briggs Institute (JBI) [8] and Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) extension for Scoping Reviews standards [9]. The results were summarised and mapped onto an evidence table to facilitate analysis and synthesis of the findings. The criteria for inclusion of studies for this scoping review are as follows: original research study; peer reviewed; published between 2016 and 2020; full text available; and pertaining to midwifery practice. The date delimiter range was chosen to book-end the systematic literature review 2006–2016 [11] undertaken to inform the development of the NMBA Midwife standards for practice. Studies exclusively related to the experience of consumers or organisational /contextual issues unrelated to midwifery scope of practice were excluded.

2.1. Research questions

Broad research questions were used to underpin the literature search on the scope of midwifery practice in relation to the current context in Australia. These included:

1. *What are the activities and tasks that midwives are educated/regulated to undertake?*
2. *What activities and tasks do midwives do, when and where?*
3. *What activities and tasks do midwives do in comparison to those performed by nurses?*
4. *What is the role and scope of contemporary midwifery?*
5. *What is the history that has led to the current context of maternity care in Australia?*
6. *What models of maternity care exist in the Australian context?*
7. *What are the key issues that impact upon contemporary maternity care in Australia?*

2.2. Database search strategy

A combination of key terms and Boolean operators were used to comprehensively review and refine the searches of key databases. A three-step search strategy was utilised (Table 2).

The first step undertaken was a limited search of the CINAHL Complete database to allow analysis of the text words contained in the title and abstract, and of the index terms used to describe the research papers. For the second step, the search terms and limiters were then refined to enable a more effective search strategy of the CINAHL Complete, Medline Complete, APA Psycinfo, Scopus databases. A hand-search of key journals and examination of reference lists was also conducted. The third step was conducted to provide an understanding of the context of midwifery practice in Australia. A search was conducted on the historical abstracts with full text to provide a background to the development of the midwifery profession in Australia.

2.3. Data analysis and synthesis

To address the research questions, the Midwife standards for practice, and the International and Australian definitions applied to midwifery scope of professional practice [1,2,10] (Table 3).

The Midwife standards for practice [10] were informed by a structured scoping review of the published literature between 2006 and 2016 [11]. A 'best fit' framework synthesis was used to test, reinforce and build on an existing published model [12] and areas of contextual variation, emerging areas of practice and gaps in understanding associated with the scope of practice and role of the midwife in Australia were identified. Midwifery scope of practice was recognised to include: 'woman-centred and primary health care; safe, supportive and

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Table 2
Database searches.

Date	Databases	Search strings	Limiters	Hits	Papers Retrieved
10/10/2020	CINAHL Complete	midwife OR midwives OR midwifery OR midw* OR nurse-midwife AND scope of practice OR roles OR regulation OR standards OR standards for practice OR registration standards OR competency standards OR professional standards NOT obstetrics OR doctor OR medicine	English language, published between 2016 and 2020, abstract available, academic journals, research article	164096 hits, 500 abstracts screened	86
15/10/2020	CINAHL Complete, Medline Complete, APA PsycInfo, Scopus, Hand search of reference lists	midwife OR midwives OR midwifery OR midw* OR nurse-midwife AND scope of practice OR roles OR regulation OR standards OR standards for practice OR registration standards OR competency standards OR professional standards NOT obstetrics OR doctor OR medicine OR dental OR pharm* OR allied health	English language, published between 2016 and 2020, abstract available, academic journals, research article, peer reviewed	1288 hits, 1288 abstracts screened	510
21/10/2020	Historical Abstracts with Full Text	midwives or midwife or midwifery AND history of AND Australia OR Australian OR Australians OR Queensland	English language	12 hits, 12 abstracts screened	7

Table 3
Scope of midwifery practice.

Definitions of Midwifery Scope of Practice	
International Confederation of Midwives [2]	"The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units. (ICM, 2017)
Nursing and Midwifery Board of Australia [10]	Midwifery scope of practice: "refers to the boundaries within which the profession of midwifery is educated, competent and permitted to perform by law". The actual scope of the individual midwife's practice will vary depending on the context in which the midwife works, the health needs of women and the baby or babies, the level of competence and confidence of the midwife and the policy requirements of the service provider."

collaborative practice; clinical knowledge and skills with inter-personal and cultural competence' [11].

3. Findings and discussion

Following review of abstracts, 517 published studies were retrieved, and synthesis of evidence from the extracted data of 96 papers was included in this review (Fig. 1).

Historical papers provided the background to the current context of Australian midwifery practice, and the empirical studies were mapped into themes. The domains of practice of the midwifery profession emerged as predominantly relationship based. At an analytical level, *Partnership with women* emerged as the central tenet of midwifery care [13,14], facilitated by the *Professional roles* of the midwife, and mediated by *Contextual influences*.

3.1. The influence of history on contemporary midwifery practice in Australia

The current context of midwifery practice in Australia has evolved from models of maternity care formed during the early era of European colonisation of Australia. Review of historical documents revealed that in the nineteenth century, women within Australian communities assisted each other with childbirth, or called upon 'handywomen' or midwives who had experience in confinements [15]. Doctors in Australia in this era were often naval or military surgeons, or medically qualified ex-convicts, now working as general practitioners [16]. The social prestige of medical doctors working in general practice was reported as low [16], and doctors had to compete financially with other low paid vocational healthcare providers [17,18]. The provision of maternity care was postulated to be attractive to general practitioners as a lucrative means to build up the clientele of individual practices [19, 20].

In 1881, nurses from the United Kingdom (UK) began the professional training of Australian nurses in Melbourne, Victoria, in the style of

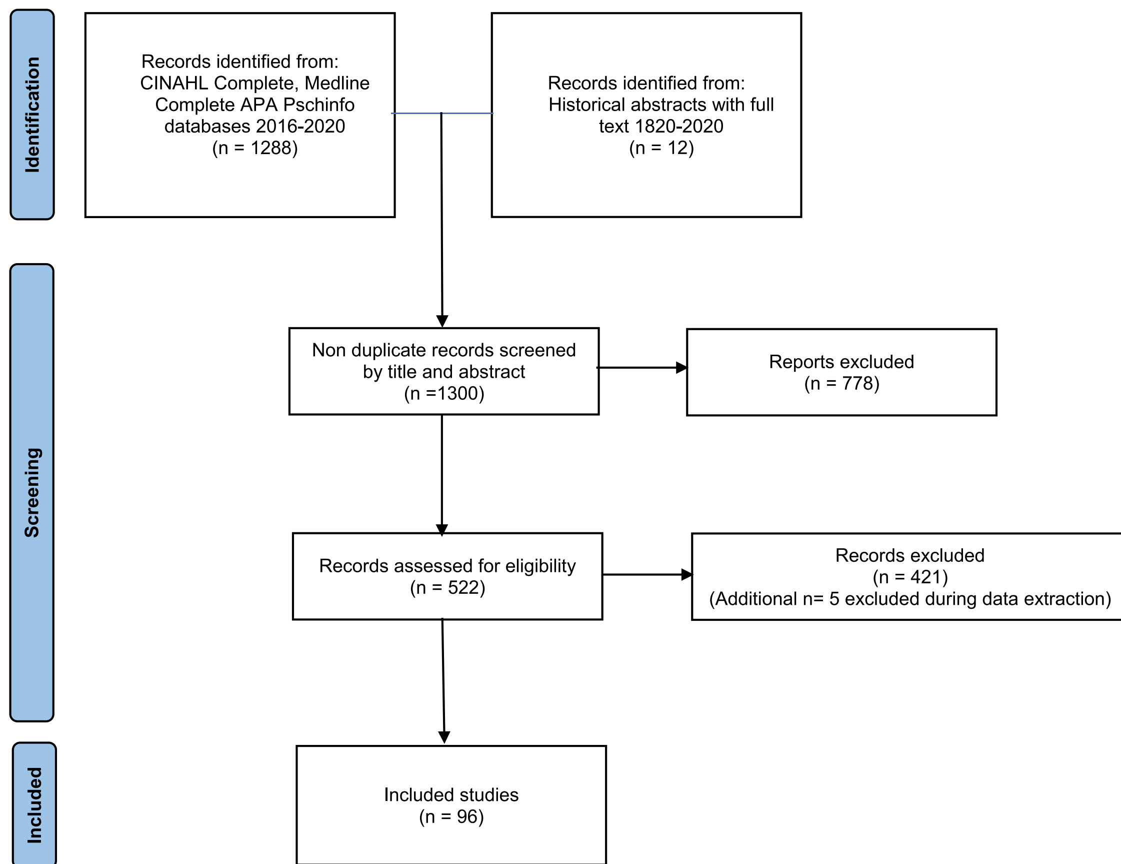

Fig. 1. PRISMA flowchart.

Florence Nightingale [21]. Tasmania was the first Australian state or territory to implement statutory regulation of midwives in 1902, followed by Queensland (1911), Western Australia (1913), Victoria (1915), and New South Wales (1926) [19]. Regulation of midwives in Queensland as 'midwifery nurses' (instituted in 1912) is argued to be 'the point at which the practice of midwifery by midwives in Queensland began a transition from lay practice in the home to qualified status in the hospital' [22]. Following this, the midwifery profession was subsumed within the regulatory jurisdiction as a specialist branch of the nursing profession. Consequently, in line with the military-style hierarchy of hospitals at the time, midwives were considered subordinate to the medical profession [22].

In Australia in recent times, most of the maternity care occurs in hospitals and is mostly provided by midwives and doctors working in collaboration in the public health system, or with an obstetrician leading private maternity care. However, significant heterogeneity between models of maternity care has been found to exist, which presents a challenge to the evaluation of outcomes from individual models of care [23–25]. To address this issue, the attributes of 129 current maternity models of care were reviewed and classified into one of eleven overarching broad model descriptors (Major Model Category) [25] (Table 4).

Table 4
The major model categories from the maternity care classification system.

Major Maternity Model of Care Categories
Private Obstetrician (specialist) care
Private Midwifery care
General Practitioner Obstetrician care
Shared care
Combined care
Public hospital maternity care
Public hospital high-risk maternity care
Team Midwifery care
Midwifery Group Practice caseload care
Remote area maternity care
Private Obstetrician and Privately Practising Midwife joint care

Note. Source: [25]

3.2. *The role and scope of contemporary midwifery practice in Australia*

As identified during the most recent update of the midwifery standards, midwifery practice is 'not restricted to the provision of direct clinical care and extends to any role where the midwife uses midwifery skills and knowledge' [11]. Midwifery practice shares similarities to the practice of the nursing profession insofar as it includes aspects of working in clinical environments within an acute hospital setting or an ambulatory community context; as well as non-clinical working in management, administration, education, research, advisory, regulatory, and policy development roles [11]. At a descriptive level, three broad themes emerged from the evidence base in relation to the activities and tasks undertaken by midwives. These included: *The scope of midwifery practice, Leadership and education,* and *Extended midwifery practice* (Table 5). Influenced by the literature reviewed, this comprehensive map of midwifery skills and scope of practice is not exhaustive.

Findings of the scoping review reveal the domains of practice of the midwifery profession are predominantly relationship-based. At an analytical level, *Partnership with women* emerged as the central tenet of midwifery care [10,26], facilitated by the *Professional roles* of the midwife, and mediated by *Contextual influences* (Table 6).

3.3. *Partnership with women*

Midwifery identity and legitimacy are centred around a primary health care partnership with the woman [11]. Midwives are educated

Table 5
Descriptive list of activities and tasks undertaken by midwives.

Scope of midwifery practice	Education and Leadership	Extended midwifery practice
Health promotion	Professional Leadership	Endorsement for ordering and interpretation of pathology and radiology
Salutogenesis	Research and evidence-based practice	Endorsement for prescribing defined medications and vaccines
Pregnancy, childbirth, and parenting education	Professional advisory representation for hospital organisational and Governmental executive boards	Private midwifery practice
Physical examination, surveillance, and assessment – woman/ foetus/ newborn	Undergraduate and postgraduate clinical teaching	External cephalic version
Psychosocial screening and referral	Preceptorship and mentorship	International Board-Certified Lactation Consultant (IBCLC)
Interpretation of pathology and radiology	Emergency procedures training and assessment (obstetric emergency/ advanced neonatal/ adult/ maternal life support)	Registered Nurse Immuneiser
Phlebotomy and cannulation	Human resources management	Advanced neonatal/ adult/ maternal life support
Communication, collaboration, and shared decision-making	Clinical governance, quality improvement, and risk management	Sexual and gynaecological health
Consultation and referral	Financial, budget and business management	Genomics
Psychological, social, and physical support		Genetic counselling
Support during perinatal loss/ bereavement		Child and family health nursing
Non-pharmacological methods pain relief		
Normal labour and birth		
Intrapartum water immersion and waterbirth		
Home birth		
Support during transition to extrauterine life		
Recognition and response to clinical deterioration and escalation of care		
Management of obstetric emergencies		
Basic life neonatal/adult/ maternal support and stabilisation		
Lactation initiation and support		
Support transition to parenthood		
Immunisation		
Contraception counselling		

Note: This list reflects the evidence reviewed and is comprehensive but not exhaustive.

Table 6
Themes and subthemes that emerged from the scoping review.

Partnership with the woman	Professional roles	Contextual influences
Empowering relationships	Professional midwifery leadership and representation	Professional midwifery leadership
Respect for autonomy and personal context of the woman	Engagement with research and evidence -based practice	Implementation of evidence-based models of midwifery care
Professional knowledge, skills, and expertise	Integrity and honesty	Positive, respectful interprofessional collaboration
Evidence-based information sharing	Competence and confidence	Respect for midwifery self-determination, independence, and self-governance
Shared decision making	Autonomy and accountability for midwifery practice	Respect for human rights and woman centred practice
Advocacy for the woman's informed choices	Proactive behaviour	Continuity of relationships
Promotion of equity and social inclusion, tackling vulnerability and inequality	Navigation between paradigms of health promotion and risk avoidance	Effective communication processes
Maintaining engagement with healthcare services	Flexibility and mediation	Positive organisational context
Promotion of public health	Supporting informed choice	Policy/ funding models supportive of professional autonomy
	Planning and documentation	Relational continuity of carer
	Consultation, referral, and collaboration	

and regulated to support the health and wellbeing of childbearing women and their families throughout the childbirth continuum, with autonomy over midwifery practice for promotion of the normal process of and prevention of complications in childbearing, and in collaboration with others when complexities arise [1]. Support and advocacy for the woman's informed choices are key to midwifery practice and are utilised to facilitate access and engagement of the woman and her family with health care services [10,27–30].

A wealth of evidence to support the development of the midwife-mother relationship through relational continuity was identified in the literature [31–37]. Compared to standard care, models of continuity of midwifery-led care have been shown to reduce the need for interventions in childbirth such as regional analgesia, instrumental birth and episiotomy [32,37]; to reduce the rate of caesarean section [31,32]; to reduce the risk preterm birth in young women [35,37]; to improve neonatal outcomes for babies of Aboriginal descent [38,39]; and to be cost effective [31].

Continuity of midwifery carer during childbearing has also been shown to have protective effects against the impact of postnatal maternal stress during natural disasters [40], and with subsequent positive effects upon the neurodevelopment of the infant [41]. As a measure of retention of staff and midwifery satisfaction, working in continuity models of midwifery led care has been associated with lower levels of stress and burnout compared to standard models of hospital-based care [42,43]. In rural settings in Scotland and New Zealand, the development of relationships between midwives and members of the local community was associated with increased sustainability of the midwifery role [44].

3.4. *The professional role of the midwife*

Salutogenesis, and the orientation of maternity care practice toward health (rather than avoiding illness), has been proposed as the means for midwives to support the wellbeing of women and babies, and to avoid of overtreatment during childbearing associated with medical paradigm of risk avoidance [45]. Wellbeing in the perinatal period is theorised to be a multi-dimensional and dynamic construct, based upon the woman's individual experience with physical/embodied, affective, and psychological/cognitive aspects [46]. However, in the current context in Australia, the medical paradigm of risk avoidance or harm prevention has emerged from the evidence as the predominant discourse during the perinatal period [47–53].

In several studies, midwives have highlighted the importance of their supportive role to enable women to understand and judge their own risks in order to make informed choices in their maternity care [47,53,54]. Findings from focus groups with midwives and childbearing women indicated that high quality midwifery-led care was facilitated by *fostering connection, providing flexibility,* and *the woman having a sense of choice and control* [33]. Similarly, being *with woman* has been reported as the 'anchoring force' of midwifery professional practice [34], characterised by midwifery philosophy, the relationship between the midwife and the woman and her partner, and empowering midwifery practice across the continuum of maternity care [34]. However, midwives' experiences of working in maternity models of care where the women are unknown to them reflect a perceived urgency to build a connection with the woman, and acknowledge the challenges of working *with woman* within the demands of the public hospital system [55].

3.5. Contextual influences upon midwifery practice

Several challenges to working within the full scope midwifery practice emerged during the scoping review. Individual midwives working within the constraints of existing hospital-based, hierarchical, or medically led health services experience challenges to fulfil their role within their full scope of practice [11,55–57]. These challenges include the 'systems' approach to childbearing prevalent within standard models of care within the public hospital system [34,55], poor leadership with a lack of support for contemporary midwifery models of care that traverse the full continuum of midwifery care [57], and 'fragmented and policy-driven medical models associated with midwives being *with institution* rather than *with woman* [34].

The strategic implementation of woman-centred care within regional and rural communities were evaluated as onerous during interviews and focus groups with key staff, due to the absence of informed leadership; lack of knowledge of contemporary models of care; inadequate clinical governance; poor workforce planning and use of resources; fallacious perceptions of risk; and a dearth of community consultation [57].

Midwifery leadership and professional representation (or lack of) at an executive level has been identified as crucial to enable midwives to work within their full scope of practice, or in models of care supported by best evidence [58,59]. Results of a systematic review revealed that a lack of midwifery leadership was detrimental to the midwifery practice climate within an organisation in the domains of work engagement and quality of midwifery care [58]. In the UK, a lack of consistency in terminology for role of the most senior midwives was identified as detrimental to the representation of the midwifery profession [59], as most units had a designated 'Head of Midwifery' rather than a the more strategic and policy-influencing role of 'Director of Midwifery' [59]. Furthermore, very few midwives in senior leadership roles (4.5%) were found to have a position on the hospital or organisational executive board, which necessitated the reporting and discussion of matters related to midwifery scope of practice to the executive board by non-midwives, for example senior nurses, department heads or medical staff [59]. Despite the protected title of 'Midwife', within federal, state and territory jurisdictions in Australia, there is no requirement for Chief Nurse and Midwifery Officers to hold a midwifery qualification [60]. Midwifery qualifications are not required within health service for Directors of Nursing and Midwifery nor within universities for Professors of Nursing and Midwifery in Australia [60].

4. Conclusion

This scoping review of the current evidence related to midwifery scope of practice in Australia using the NMBA Midwife Standards for Practice as an analytical framework, has revealed the pivotal role of midwifery partnership with women; midwifery autonomy and advocacy in the provision of woman-centred care; and the balance of risk avoidance in childbearing with a salutogenic, health promotion paradigm to facilitate choice for women. Continuity of midwifery care has been proven to be a safe, cost-effective model of care, with potential benefits for all women regardless of level of obstetric risk.

However, tensions were identified that challenge the full potential of midwifery scope of practice in the both the current Australian and international midwifery context. A mismatch has been identified between recommendations from the evidence-based published literature and the current administration and funding of health care policy, and models of publicly funded maternity care provision in Australia. There is an urgent need to review the representation of the midwifery profession at the leadership, executive and policy levels to support the role of the midwife for provision of evidence-based maternity care. This includes support for midwives to practice with professional autonomy within their full scope of practice to facilitate continuity of carer, relationship building and partnership with women, and to reduce midwifery burnout.

Ethical statement

None declared.

Funding

None declared.

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