



australian
nursing federation

Submission to the National Health and Medical
Research Council on the consultation draft -
National Guidance on Collaborative
Maternity Care

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1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia.

The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership of over 175,000 nurses and midwives, members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private health and aged care sectors.

The ANF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANF is pleased to provide comment to the national consultation being undertaken by the National Health and Medical Research Council on behalf of the Australian Government Department of Health and Ageing (DoHA) in relation to the draft document - *National Guidance on Collaborative Maternity Care*.

Of the 245,491 registered nurses in Australia in 2007, 52,374 were authorised as midwives, with 18,200 identifying as having a primary work place of midwifery.¹ Within the membership of the ANF there are approximately 11,000 midwife members. We therefore have a genuine interest in professional, industrial and regulatory issues pertaining to midwives.

Given the size of the midwifery cohort within our membership it is disappointing that the ANF was omitted from the stakeholder consultations.

2. Midwives

Midwives, as members of a self-regulated health profession, are autonomous providers of midwifery care under the nurses and midwives Acts within the State/Territory in which they are regulated and in which they practice. This means that they have independent authority to act within their scope of practice and they are accountable for their own clinical decision-making and the outcomes of their actions when caring for women in the ante-natal, intra-partum and post-natal phase of pregnancy.

Midwives and nurses together form the largest health professional group in Australia, comprising over 55% of the entire health workforce² and providing health care to people across their lifespan. Midwives and nurses are also the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional and industrial organisations; and practice across all socio-economic spheres .

The practice of midwives' is described as being woman centred; a primary health care discipline founded on a partnership relationship between women and their midwife/s. Contemporary midwifery practice is based on a well health model of care..

Midwives contribute to the planning of care centered around a woman's and her family's health needs, her expectations and aspirations and recognise every woman's responsibility to make informed decisions for herself, her baby and her family.³

Midwifery practice includes prevention and health promotion as well the development of care plans in collaboration with the women and other health practitioners to facilitate normal birth and minimise risk. Women assessed as either a medical or social risk are referred at the most appropriate point to the most relevant health practitioner and further care by the midwife may be provided within the context of a multidisciplinary approach.⁴

Midwives work in a unique partnership with a woman and give support, care and advice during the antenatal period, during birth and in the postpartum period, and care for the newborn and infant. Midwifery practice includes health counselling and education, not only for the woman, but also within the family and the community. Involved in this is antenatal education and preparation for parenthood, as well as follow up care of the woman in regards to sexual or reproductive health and care and assessment of the young child.

Midwives seek assistance should the womens' requests not be consistent with best practice standards or contrary to safe practice. The Code of Professional Conduct for Midwives in Australia carries the statement that *Midwives practise in a manner that recognises the woman's right to receive accurate information; be protected against foreseeable risk of harm to themselves and their infant(s); and have freedom to make choices in relation to their care.*⁵ Midwives also advocate on behalf of their clients, particularly those women from minority groups whose care might impact on traditional beliefs and practices, and often associated within an institutional context.

3. General comment

The ANF supports the position of the International Confederation of Midwives (ICM) that “all women will benefit when there is continuity and collaboration among the range of health care workers ... where such collaboration is based upon mutual trust and respect”.⁶

The fourth paragraph in the *Introduction* to the NHMRC draft *National Guidance on Collaborative Maternity Care* (Guidance) document states that in order for midwives to access the provisions of the maternity reform package, they will be expected to demonstrate they are working in collaborative arrangements. However, unless General Practitioners and obstetricians have similar obligations to demonstrate that they too have collaborative arrangements in place, the aims of the Guidance are unlikely to be achieved. The Guidance document needs to reflect the fact that there must be a two-way commitment to collaboration in maternity care. Currently the document makes reference to midwives working collaboratively with medical colleagues but does not refer to medical colleagues working collaboratively with midwives. This omission leads to the erroneous inference that midwives are in a subservient position rather than in a collegial position with medical colleagues in collaborative maternity care.

4. Specific comments

4.1 Maternity care collaboration: definition and principles

Collaborative care involves collaboration with the woman (respecting their physical, emotional, social and cultural needs) and for the woman (creating a safe, high-quality, evidence-based and woman-centred environment). The ICM supports the view that collaborative care is grounded in continuity of care and that this collaboration “should be constructive and focused on women’s needs at every level”.⁷

In their article on collaboration, Way, Jones and Busing (2000) highlight the fact that “collaboration has become a buzzword that too few healthcare planners or providers can accurately define”. Through their project they defined collaborative practice “as an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided”.⁸ The ANF is supportive of this definition and the notions of collaborative practice espoused by Way (*et al*, 2000) that it involves “working relationships and ways of working that fully utilises and respects the contribution of all providers involved”.⁹ Of the seven essential elements identified through their research project as being integral to successful collaborative practice the ANF considers that it is worth noting the commentary on ‘autonomy’:

Autonomy involves the authority of the individual providers to independently make decisions and carry out the treatment plan. Autonomy is not contrary to collaboration and serves as a complement to shared work. Without the ability to work independently, the provider team becomes inefficient and work becomes unmanageable. Both partners need to fully understand and support practice autonomy, as well as, shared decision making from a liability perspective.¹⁰

With reference to the proposed definition and principles of maternity care collaboration in the NHMRC draft document (p. 3) the ANF supports the statements, with suggested amendments as shown in bold type:

Definition:

*In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred **continuity of care**. Collaborative maternity care enables women to be active participants in their care.*

Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman's care, especially for the person the woman sees as her maternity care coordinator.

Principles:

(only those where suggested amendments be made are shown)

*1. Maternity care collaboration places the woman at the centre of her own care, while supporting the professionals who are caring for her (her carers). Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial, **spiritual** and clinical needs.*

Insert a new principle before the existing No. 4:

Collaboration is a process where two or more independent professionals work together with the woman to achieve common goals by sharing knowledge, learning and building consensus.

*4. Collaborating professionals, regardless of the model of care, establish a clearly defined and inclusive (two-way) communication strategy using **language that is sensitive and supports professional trust.***

*6. Collaborating professionals respect and value each others' roles, **including skills, scopes of practice and clinical decision making**, and provide support to each other in their work.*

The ANF agrees that there should be flexibility in collaboration in maternity care to allow for the diverse needs of women and the communities of which they are a part. The essential concern should be as the ICM describe it, that the collaborative care “should be constructive and focused on women’s needs”.¹¹

4.2 Key elements of collaborative care

The ANF supports the elements of collaborative care as suggested by the NHMRC draft document with some minor amendments:

- woman-centred care and communication - **ensuring a woman’s involvement in communication about her care to allow her to make informed decisions based on best evidence**
- communication among professionals
- awareness of **each other’s** disciplines and autonomy
- responsibility and accountability
- cooperation and coordination
- mutual trust and respect
- policies, procedures and protocols
- inter-professional learning
- organisational support
- systems **of governance**

The ANF concurs with the commentary in Chapter 2 in relation to the above named key elements of collaborative maternity care.

With respect to protocols and procedures it is the view of the ANF that these must be at local facility level and not at national level. The ANF does not support national protocols as this would risk introducing unnecessary inflexibility and impeding development of locally driven services which can meet specific needs of groups within individual communities.

4.3 Establishing collaboration

4.3.1 Credentialling

While the key areas to consider when establishing collaboration, as outlined on page 21 of the draft Guidance document from the NHMRC, are fine, some of the commentary to follow in Chapter 3 appears medico-centric. For example, the references to credentialling use a definition and process which applies to the medical profession. For the medical profession, credentialling is between an individual and an organisation. For the nursing and midwifery professions credentialling is between an individual and a professional organisation. The Coalition of National Nursing Organisations defines credentialling as:

The process by which an individual nurse is designated as having met established professional competency standards, at a specified time, by an agent or body generally recognised as qualified to do so. In Australia this is a voluntary process for nurses and credentialling is organised by the professional organisation and not nurse regulatory authorities. The purpose of credentialling or certification is to assure other professionals and the public that the person has mastered the skills necessary to practise a particular specialty and has acquired the standard body of knowledge common to that specialty.¹²

It is the view of the ANF, that as credentialling is an entirely voluntary process for midwives in Australia, this should not be a requirement for clinical privileging of midwives to health services. Given the report states that medical practitioners who are part of the credentialling process could act to refuse access for midwives to health care facilities if there is 'real or perceived competition' between themselves and midwives (3.2.10 of the NHMRC draft Guidance document), strategies need to be implemented to ensure such refusal of access does not occur.

4.3.2 Collaborative arrangements

For midwives, collaboration with other health professionals is already a mandated part of midwifery practice. The regulatory professional practice framework within which midwives work - National Competency Standards for the Midwife, Codes of Ethics, Codes of Professional Conduct, National Decision Making Framework, and other standards as will be applied by the Nursing and Midwifery Board of Australia (NMBA) after 1 July 2010, requires collaborative practice.

Collaborative arrangements for eligible midwives, as agreed to by nursing and midwifery organisations* is demonstrated by the following:

(* Australian College of Midwives, Australian Nursing Federation, Australian Nursing and Midwifery Council, Maternity Coalition, Australian Private Midwives Association, and Royal College of Nursing, *Australia*)

- a self declaration of safety and competence to practise within the professional practice regulatory framework for nurses and midwives in Australia as required by the NMBA on annual renewal of registration;
- a signed declaration by the midwife detailing the midwife's commitment to:
 - o practice in accordance with the 'collaborative guidance' as determined by the NHMRC once completed and endorsed by the professions,
 - o collaborate with other health professionals with the consent of the woman as outlined in the Evidence of Collaborative Arrangements Flowchart (refer Attachment A),
 - o collaborate in accordance with the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral*¹³, or other agreed national guideline.
- maintenance of a comprehensive record in each woman's maternity care notes:
 - o documenting prospective plans for consultation and referral
 - o history of consultation, referral and discharge which is also communicated to other care providers as per flow chart
 - o maintained in triplicate with copies for woman and collaborating doctor or hospital.

Evidence of inadequate collaboration or other concerns may result in investigation by Medicare's Professional Services Review agency, and/or referral to the NMBA for investigation.

In identifying how a collaboration can work the ANF considers that midwives and medical practitioners do not need a written contract with each other to make sure that collaboration occurs. Collaborative practice is long standing between health professionals and collaborative arrangements do not need to be formalised in legislation. Midwives and their medical colleagues act ethically, professionally and within a legal framework.

4.3.3 Sample brochures

The sample brochures referred to in Chapter 3 of the draft NHMRC document (and attached at Appendix 2 of that document) are seen by the ANF as excellent information tools. However, there is a question posed on the second page of the first brochure which requires clarification: "What are the opportunities to evaluate the leadership?" It is the ANF's view that collaboration does not mean one profession dominating or overseeing another. It means respecting each other's interest and professional responsibility. In relation to maternity care, it requires midwives and medical colleagues having the confidence that each will inform and discuss client needs with the right clinician at an appropriate time. It also means that each health professional will act in a respectful professional manner at all times, recognising the limit of one's scope of practice, calling on another professional if needed. Existing regulatory processes for each profession which underpin professional practice ensure quality, safety, accountability and responsibility in the public's interest.

4.3.4 Roles and responsibilities

While a woman may enlist the assistance of a 'doula', or 'strong women', such individuals are not health practitioners, and should not be part of the collaborating partnership/team. They are there to support the woman during her pregnancy, labour and birth – they are not part of the health professional team vested with the responsibility of ensuring optimal outcomes for mother and baby. 'Hospital personnel' needs more definition – if the intent is to include, for example, a social worker or pastoral care worker, then that should be stated. The term 'hospital personnel' is too broad and all encompassing to get a sense as to whom the document may be referring.

4.3.5 Rural and remote areas

With reference to the sixth dot point – Access to hospitals: such requirements may be 'setting the bar too high'. That is, such requirements may be too onerous for a midwife to undertake, and may militate against midwives in rural and remote areas choosing to become endorsed as eligible midwives. This section should also be read in conjunction with the commentary on credentialling for midwives at 4.3.1.

4.4 Clinical resources for collaboration

The ANF supports the use of clinical guidelines which promote safe, competent practice which is based on the best available evidence; and which has mechanisms for review and updating according to recommendations of validated research.

As has been previously noted, protocols and procedures must be developed at local facility level and not at national level. The ANF does not support national protocols as this introduces unnecessary inflexibility and impedes development of locally driven services which can meet specific needs of groups within individual communities.

4.5 Monitoring and evaluation

The ANF is supportive of mechanisms for on-going individual practitioner reflection on practice, and peer review. In addition, there must be processes at the collaborative care and organisational levels, for monitoring and evaluation that collaborative arrangements are benefiting the client group – women – and the health professionals.

4.6 Case studies

The ANF notes that none of the case studies refers to independent midwives in private practice.

5. Conclusion

The ANF has taken this opportunity of public consultation to provide advice to the National Health and Medical Research Council on the development of a document which provides guidance at a national level on collaborative maternity care.

With a cohort of approximately 11,000 midwife members within our total membership of over 175,000 the ANF has a genuine interest in professional, industrial and regulatory issues pertaining to midwives.

It is important that the arrangements for collaborative practice are based on mutual trust and respect, with a focus on the needs of women, their babies, and their families. Essentially the ANF has a primary concern to ensure that midwives are able to provide effective, efficient and safe midwifery care for women in our community, but cautions that in order for this to be realised, GPs and obstetricians need to be expected to provide similar evidence of collaboration as that to be required of midwives.

The ANF looks forward to being involved in the finalisation of the Guidance document and to participating in the evaluation and review process of the collaborative arrangements for maternity care.

References

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3. Australian College of Midwives, *ACM Philosophy Statement for Midwifery*. Available at www.midwives.org.au.
4. Australian Nursing and Midwifery Council. 2008. *Code of Ethics for Midwives in Australia*. Available at: <http://www.anmc.org.au>.
5. Australian Nursing and Midwifery Council. 2008. *Code of Professional Conduct for Midwives in Australia*. Available at: <http://www.anmc.org.au>.
6. International Confederation of Midwives. 2008. Position statement: *Collaboration and partnerships for health women and infants*. Available at: <http://www.internationalmidwives.org>
7. Ibid.
8. Way, D., Jones, L., and Busing, N. *Implementation Strategies: "Collaboration in Primary Care- Family Doctors & Nurse Practitioners Delivering Shared Care": Discussion Paper Written for the Ontario College of Family Physicians*. May 18, 2000. Available at: <http://www.cfpc.ca/english/ocfp/communications/publications/default.asp?s=1>
9. Ibid. p. 3.
10. Ibid. p. 4.
11. International Confederation of Midwives. Loc cit.
12. Coalition of National Nursing Organisations. 2004. (2nd ed). *Glossary of Terms: Criteria for Specialties in Nursing; Principles of Credentialing for Nurses*. Adapted from the Canadian Nurses Association 1984 position statement *The Regulation of Nursing*. Available at: http://www.conno.org.au/pdf/NNO_Glossary_of_Terms.pdf.
13. Australian College of Midwives. 2008. (2nd ed.). *National Midwifery Guidelines for Consultation and Referral*. Available at: <http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/cms.r?PageId=10037>

Evidence of collaborative arrangements

Eligible midwife

Woman
Either by referral or self referred

**Initial consultation requesting
midwifery care / advice**

**Eligible midwife asks woman
'do you have a GP, obstetrician or
any other health professional
involved in your care?'**
*Request consent to contact.
Document in case notes.*

**If woman does not have a
GP, obstetrician or other
appropriate health professional:**
*Suggest GP, obstetrician or
health service that eligible midwife
already collaborates with.
Document outcome in case notes.*

**If woman has a GP, obstetrician
or appropriate health professional
and consent is given:**
*Write to GP, obstetrician or
health professional and keep
them informed throughout care.
Document in case notes.*

**If no consent is obtained to involve
other health professionals:**
*Eligible midwife to document
in case notes.
Hospital booking to be arranged
by the eligible midwife and
documented in case notes.*