THE JEWEL IN THE CROWN

A case study of the New Zealand College of Midwives Standards Review Process in Wellington

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A thesis submitted to
Victoria University of Wellington
in partial fulfilment of the requirements for the degree of
Master of Arts (Applied) in Midwifery

Victoria University of Wellington

1998

Abstract

In 1990 New Zealand midwives regained the legal right to practice autonomously. Large numbers of midwives exited the hospital system to provide continuity of care both in the community and in the hospital. These midwives practise independently and are funded by the state to do so. The New Zealand College of Midwives has developed and promoted a midwifery model of partnership, incorporating this model into its Code of Ethics and Standards for Practice. In its commitment both to professional development and to accountability, and in partnership with consumers of maternity care, the College developed the Midwifery Standards Review Process. This process involves the midwife in an annual review of her practice. The midwife gathers and collates her statistics, and measures her practice against the NZCOM Standards for Practice. Consumer feedback forms are sent directly to the review co-ordinator. All this information is presented to a panel consisting of two midwifery peers and two consumer representatives. Together with the midwife they discuss her year's work and develop goals for the coming year. The purpose of the review is to provide the midwife with a supportive, educative environment in which to reflect on her practice while at the same time providing an avenue for professional accountability.

This study describes the Midwives Standards Review Process in detail using a case study approach. It finds that the process is a unique and innovative addition to the ways peer review and reflective practice can be provided. It identifies the issues of quality assurance, reflective practice, supervision and competence as being of most relevance. In particular it develops the ideas of how reflective practice can be enhanced within a quality assurance model. It recommends that further research is undertaken to ascertain whether midwives using the process find it useful, in particular how it has assisted them in their professional development. Further research may also increase the body of knowledge on the nature of reflective practice and how it is best facilitated.

Acknowledgements

Thanks are due to many people who have assisted me in this work.

I wish to acknowledge the midwives and consumers who have put in so much time and thought into the development of the review process. Their commitment to ensuring that the quality of midwifery care is both enhanced and made transparent has been impressive. In particular I would like to mention Joan Donley. Joan's vision initiated the whole review process. She has been an inspiration and guide for many, including myself as I ventured into home birth practice. The title of this thesis, "The Jewel in the Crown", came from Joan's comments when I interviewed her for this work, and I dedicate this thesis to her.

I would also like to thank Rae Clark, the Wellington co-ordinator. Rae has put an enormous amount of work into developing the review process in Wellington. Her commitment is an inspiration. She has a wonderful amount of energy, having given birth to two more beautiful babies along the way. It has been a pleasure to work with her.

Maralyn Rowley has been my supervisor and I thank her for her absolute clarity and very helpful comment. Her support and ready feedback have always been freely and efficiently available. I have appreciated her enthusiasm for my project and her encouraging words.

My family have been amazing. Peter, my partner, has provided the ultimate support and encouragement. His love and companionship have given me the space for thought and the energy for creativity. My children have been right behind me and have never complained about my need to work. They have been very patient about my domination of the study and the computer. I look forward to having some more energy for them although they may miss "Dial-a Pizza".

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ENTRY VIGNETTE

Cathy sits at the kitchen table with a coffee and opens a large brown envelope. Tim has just gone down for his afternoon nap. With any luck he will have a couple of hours so Cathy can have a good, uninterrupted read of her mail.

She has been quite involved in Parent Centre since Tim was born and has enjoyed the company and the stimulation since she gave up work as a computer analyst. They nominated her as their representative on one of the College of Midwives review committees. She attended their training session last month and next week does her first review for real. She is quite apprehensive about the experience but is looking forward to having a go at something new and challenging.

The package contains the midwife's analysis of her year's work, reflections on her practice, a comparison with the College of Midwives Standards of Practice, some objectives and a summary of her consumer feedback forms. As she reads through the papers, Cathy feels a little daunted but she focuses on the standards. She is reassured that there will be two midwives also on the committee who will be able to help interpret the more obstetric focused data and that the other consumer rep on the committee has done quite a few reviews before.

She is fascinated by how this midwife works, notes her comments and picks up quite a few points that she would like her to expand on. The consumer feedback is very impressive. This midwife does seem to work very hard. She remembers that the process is intended to be supportive and encouraging and can see that this midwife has already noted for herself where she can develop her practice. The review is next Thursday night. This is when she will meet first with the other three reviewers, then with the midwife and then do the summary. Quite a lot to cover in three and a half hours. She hopes Tim will go to sleep for John that night without a breast feed.

CHAPTER ONE: BACKGROUND STATEMENT

The New Zealand midwifery story

The story of midwifery in New Zealand mirrors to a large extent international developments in maternity care. Increasing medicalisation in Western societies has led to the erosion of the role of the midwife to obstetric nurse working primarily as the doctor's assistant, providing fragmented care in hospitals (Donley, 1986).

The New Zealand scene has been no exception. The battle for the control of birth by doctors progressed throughout the first half of the twentieth century. Increasingly women went to hospitals to give birth under the direction and control of doctors. The development of the obstetric specialist in the 1930s saw further erosion of the midwife's role. In order to create Obstetrics and Gynaecology as a valid speciality, doctors claimed birth as a medical event which was to take place in hospital under their supervision. Midwives were invisible in this process (ibid.).

In New Zealand, successive legislative amendments and policy changes from 1970 onwards led to the near annihilation of midwifery. The amendment to the Nurses Act in 1971 required midwives who had previously been able to provide autonomous care, to be under the supervision of a medical practitioner. This amendment reduced the role of the midwife to that of maternity nurse. Its passing caused hardly a ripple due in large part to the fact that very few midwives at that time provided autonomous care. Only home birth practitioners did so and there were few of these, such had been the effect of the medicalisation and hospitalisation of birth.. The New Zealand Nurses Association (NZNA) which at that time represented midwives' industrial and professional interests did not protest. At the same time maternity services were being increasingly centralised, resulting in the closure of most small maternity units, both rural and urban (Donley, 1995).

It was not until changes were made to midwifery education in 1978 that midwives would start to become aware of and attentive to their loss of autonomy. Most midwives had till this point also accepted the medicalisation of birth as the norm. They were educated in six month apprentice-style hospital-based programs in the St Helen's hospitals. Nursing registration was a prerequisite and nurses were on full pay while they trained. This was replaced in 1978 by an eight week 'midwifery option' within an Advanced Diploma of Nursing. This was provided in tertiary institutions and was student based.

It resulted in a severe shortage of midwives. Large scale importation of midwives from Australia and Britain ensued. Many of these were New Zealand nurses who had chosen to go overseas to train, either because they saw the New Zealand training as deficient or because they wanted to be paid while they trained. In 1984 for example, 80% of the 144 midwives who registered in New Zealand had qualified overseas, 33% of these were New Zealanders. That same year, New Zealand trained only 27 midwives (Donley, 1986, p.104).

Further legislation in 1983 allowed nurses who were not midwives to provide maternity care. It also prevented direct-entry midwives, those who had registered without a nursing qualification, from practising independently in the home. There was also a proposal by the Nursing Council at this time to make midwifery simply a post-basic nursing certificate rather than a separate legal registration. Nursing was to completely subsume midwifery (Donley, 1986). This would have meant the end of midwifery in New Zealand.

The struggle for New Zealand midwifery from 1983 to 1990 culminated in the 1990 amendment to the Nurses Act. This saw the full reinstatement of autonomy for the midwifery profession. It enabled midwives in New Zealand to care for women throughout the childbearing process without medical supervision. Amendments were required to other Acts of Parliament to enable midwives to prescribe, to access laboratory services and ultrasound screening and to access General Maternity Services (GMS) funding at an equal rate of pay with doctors. This remarkable turn of events

happened because of the interweaving of five strands. These strands include the political action by midwives, the growing involvement of consumers in health affairs, a developing home birth movement, a changing New Zealand society and a political philosophical shift. This chapter will explore these strands in some detail and place my own experience within the context of these changes.

Political action by midwives

The 1983 Nurses Amendment Act, along with the proposal by the Nursing Council to de-register midwives and the acute shortage of midwives in New Zealand all served to provide an environment which finally alerted midwives to their plight. Home birth midwives and hospital midwives, previously at odds with each other, joined forces within the Midwives Special Interest Section of the NZNA to fight for their existence. Midwives finally woke up, and became an extremely effective and active political force. Midwives who had never been active before 'came out'. They lobbied at every level and at every opportunity.

An important feature at this time was that the midwives were at odds with their own representative body, the NZNA. There was much discussion about separating from NZNA over this period and a growing acceptance that midwifery had a basis fundamentally different from that of nursing. For midwives it seemed that the link with nursing was putting them at risk and must inevitably be severed..

To do this midwives challenged the NZNA Policy Statement on Education to gain separate midwifery education. In 1985 they succeeded in having the NZNA adopt the WHO definition of a midwife ('a midwife is a person...' not necessarily a nurse) which was a major achievement. Midwives had turned up en masse to local NZNA branches to get this remit through. Finally, after many attempts by the Midwives Section to influence NZNA policy, which persistently overruled midwifery interests in favour of nurses, midwives had had enough. In 1988 they severed their connection with nursing. At their National Midwives Special Interest Section Conference in Auckland they

simply announced the inauguration of the New Zealand College of Midwives and walked away from nursing. This was to be vital decision. It had been prompted in the end by Joan Donley (New Zealand's doyen of midwives) in her speech to that conference: "Are You Midwives or Moas?"

Consumer movement

The other crucial decision midwives made at this time was to join forces with consumers of maternity care. From its very beginnings, the New Zealand College of Midwives (NZCOM) had a significant amount of consumer input. Its first constitution allowed for consumer representation at all levels of the organisation including its National Executive. It has remained committed to partnership with consumers. Its philosophy and code of ethics state that midwifery takes place in partnership with women (New Zealand College of Midwives, 1993).

Consumers of maternity care were also interested in forming links with midwives. The medicalisation of birth and the increasing use of technology over the 1970s caused some women to be very concerned about their lack of choice and control in birth. The Homebirth Association was formed in 1978, and together with the domicilary midwives began to challenge the medical model of birth (Donley,1992). Both Parent's Centre organisation and the Home Birth Association sought to re-establish childbirth as a normal life event. They saw the survival of the midwife as the cornerstone of this process.

The creation of 'Save the Midwife', a consumer led organisation, aimed to restore the role of the midwife and attend to the poor state of maternity services in New Zealand. (Guilliland and Pairman, 1995). 'Save the Midwife' also viewed any link between nursing and midwifery as being likely to reinforce the medical model of birth so was a firm supporter of direct-entry education for midwives (Davies, 1997).

There was also over this time a growing concern about women's rights within the wider health system. In the 1970s National Women's Hospital, the nation's leader in

O&G care, conducted an experiment on cervical cancer. Without gaining women's consent treatment was withheld from a group with established cervical abnormalities. As the mortality of this control group increased, it was two health activists, Sandra Coney and Phillida Bunkle, who alerted the public to the plight of these women and to the lack of informed consent and supervision of the study. It went on far beyond the point when it should have been stopped (Coney, 1988).

An enquiry undertaken in 1988 by Judge Sylvia Cartwright into the experiment revealed these facts to the public. There was widespread outrage at how women had been treated, which reverberated through all areas of health. The Government's response was to develop clear guidelines for informed choice and consent based on the principles of autonomy, responsibility and accountability (Department of Health, 1991). These are now entrenched in the New Zealand health environment. It is now expected that consumers will be actively involved in health care both at an individual and organisational level.

The home birth movement

Although home births have always been a legal option in New Zealand they were increasingly frowned upon by the medical profession. There was a small but growing group of women and midwives who resisted the increasing medicalisation of birth which was occurring through the 60s and 70s. These home births were happening mainly in Auckland and it was here that the first Home Birth Association was established in 1978 (Donley,1992). This was the birth of the partnership model. Midwives and consumers joined forces, working together for the improvement of maternity services

Home birth in New Zealand became an option that more families were choosing. In 1982 there were 461 home births, a 32% increase in two years. Home birth associations had been formed in nine centres (Donley, 1992, p15). The movement became politically active in an environment which was very hostile. Health authorities, obstetricians, the NZNA and many midwives working in hospitals were strongly

against home birth and saw it as a dangerous process. The 1983 release of the Health Department Report "Mother and Baby at Home: The Early Days", which spoke strongly against home birth, and the passing of the Nurses Amendment Act that same year which restricted the practice of midwifery to those who were registered nurses, served as a further catalyst for political action by home birth advocates. It was at this point that domicilary midwives, consumers and hospital midwives began to join forces to fight for a viable home birth option and for midwifery autonomy.

Many midwives working in hospitals at this time, prompted to a large extent by the demands of the consumers who were using their services, were starting to challenge the increase in the medicalisation of birth. These midwives became sympathetic to home birth and were crucial actors within the NZNA Midwives Special Interest Section which was at the time the only arena where midwives had a national voice.

Home birth continued to grow and the battle for control continued. By 1988 there had been significant headway made by the home birth movement. Although the medical establishment remained vehemently opposed, home birth was becoming much more of an accepted option. Health authorities, (newly restructured by the health reforms), hospital managers and the public were all getting used to the idea of home birth as an acceptable alternative. Despite appalling wages, (a home birth midwife could earn more on the dole) midwives were increasingly moving out into the community to provide a home birth service. It was at this stage that the Home Birth Association in Auckland developed its midwives review process. This process was seen as a way of giving legitimacy to home birth practice and as a way of monitoring the midwives newly emerging from hospitals. It is this process that was the forerunner of the NZCOM Midwifery Standards Review Process, the subject of this study. The story of the home birth midwives review process will be developed in Chapter Four.

Although home birth was an option that both women and midwives were choosing, there was not a corresponding growth of doctors willing to be home birth practitioners and in many areas there was none. This meant that women could not legally have home births as by law a midwife could not practice without medical supervision. A significant reason for the 1990 amendment was to enable women anywhere to give

birth at home, especially in areas where general practitioners were not prepared to get involved. As home birth was increasingly seen as a right, statutory change was needed to allow women that right. This was one of the core reasons behind the push for midwifery autonomy. For those of us who were practising domicilary midwives at the time, this change was more that we could ever have hoped for. Not only could we now provide a home birth service without doctors but we could now claim the same rate of pay.

New Zealand society

The nature of New Zealand society over this time also contributed to this change. New Zealand, traditionally a land of peace and plenty with little overt strife, grew through the last three decades into a country where economic and social pressures required massive reform. We ceased being linked closely to Britain as mother country and refocused our allegiance to the Pacific. Economic near-disaster in the 1980s led to radical economic reform which split the country into rich and poor. Social security 'from the cradle to the grave' could no longer be guaranteed. New Zealand followed the world into right wing politics and led the world in economic reform. Individualism flourished at the expense of community.

As a contrast, the revival of the issues for Maori, New Zealand's tangata whenua or indigenous people centred on the Treaty of Waitangi and the effects of colonisation. New Zealand is in the process of acknowledging many breaches of this treaty and is providing some reparation to Maori for them. This has led the country to look at issues of biculturalism and has meant that many New Zealanders have been made increasingly more familiar and comfortable with the concepts of partnership, participation and protection. For midwives in New Zealand these concepts have been built into their College philosophy. It was this concept of partnership which midwives and consumers picked up and developed in their fight for the existence of midwifery and for the reinstatement of birth as a normal life event (Guilliland, 1995).

Political changes in New Zealand

Politics of the 1980s in New Zealand changed radically. Partly as a response to fiscal crisis, the Government did a major about face in the philosophical approach to its role. A general ideological shift to the right led to the government minimising its role in state affairs. This resulted in corporatisation, privatisation, and deregulation. Competition became a central concept in state activities, including health. The adoption of economic rationalism, managerialism, deregulation, and anti-protectionism led to, among many other things, a decrease in the power of previously protected professions. Choice and consumerism were of paramount importance (Boston, 1991). Astute midwives and consumers saw that midwifery autonomy fitted this changed ideology perfectly, and they made good use of it. They lobbied by positioning midwifery autonomy as a way of increasing choice of place of birth and of increasing competition between providers of maternity services. The final piece of the political picture was a Minister of Health who was both part of a Labour Government and a woman. She had had significant difficulty negotiating with doctors over funding for medical services and had attempted unsuccessfully to create an option for capitation-based funding for General Practitioners.. She also restructured the health system, making secondary services more accountable for cost. She was very sympathetic to what midwives wanted and agreed to alter the Nurses Act giving midwives autonomy. Parliament passed the Nurses Amendment Act in 1990. New Zealand would see a change in the way maternity care was given that it had not even begun to contemplate. The effects of the legislative change went much further than simply facilitating greater access to home births.

Since midwifery autonomy

From 1990 to 1998, maternity care in New Zealand changed radically. The 1990 Amendment to the Nurses Act was a very broad piece of legislation. The wording stated that a doctor and/or a midwife could now provide maternity care. It did not simply permit home birth midwives to work without medical supervision but enabled New Zealand women to have a midwife of their choice provide care with or without

medical involvement, in hospital or at home. Large numbers of midwives exited the hospital system and set up in independent practice to provide midwifery care. In general they worked in shared care arrangements with doctors, providing some antenatal visits, the labour and delivery care in hospital, and some postnatal care in the home once the mother had left hospital.

Both the doctor and the midwife could now make a claim on the Maternity Services Benefit (MSB), the state funding arrangement, and have access to hospital facilities. Prior to this only doctors could do so. Midwives could now be very well paid. Before 1984 domicilary midwives received $167 per case, in 1988 the midwives' payments rose to $350 per case (Donley, 1992). Under the MSB midwives, whether providing home or hospital birth care, could claim around $2000 per case depending on the number of visits and length of the labour. This was one of the main reasons why so many midwives took up independent practice. They did in the main, however, continue to work with doctors and in hospitals, a fact that dismayed many of the midwives and consumers who had fought for the right to be autonomous practitioners and who were committed to home birth.

While the Government created this new way for women to be cared for, it did nothing to monitor the effect of the changes. Just as the doctors had no legislative requirement for the monitoring of their practice standards and outcomes, neither did the midwives. There was and still is no national perinatal database to assess the outcomes of care, be it medical or midwifery. The only significant national data kept was the budget of the MSB which understandably increased significantly. The New Zealand population in large numbers, had taken up the opportunity of having a midwife of their choice care for them. They also often wanted their doctor involved as well. This doubled the claims made on the MSB.

Doctors, however were horrified and fought the changes with vehemence. After having refused to negotiate MSB reforms with the midwives they were able to force the instigation of a Maternity Services Tribunal This resulted in a reduction in the MSB in areas where midwives made most claims, e.g. labour care, and an increase in the funding where doctors were usually involved e.g. antenatal visits. Midwives, now

represented by their own College, did manage to persuade the Tribunal to accept the legal right of midwives to practice autonomously. The Tribunal reiterated the concept of equal pay for equal work. Although their incomes were reduced, midwives viewed this as a victory.

Further heath reforms in 1991 created a funder/provider split. Health providers were now to contract with the health funding agencies to provide health care. This has led to a multiplicity of practice models. The trend now is for groups of providers to collectively contract. Midwives are now, in the main, part of Maternity Provider Organisations (MPOs) which contract for funding. Some examples are:

- Small or large collectives of midwives providing midwifery-only care in home or in hospital
- Large groups of obstetricians, general practitioners and midwives working in a shared care arrangement
- A local home birth organisation contracting midwives to provide home birth services and contracting for home help and mothers groups.
- A capitation based primary health care practice, with employed midwives providing the maternity care for the practice population.

All these options and more exist at the moment in New Zealand. The funding arrangements have now completely changed. There is now no longer a fee for service system with an open ended budget. Instead there is a single payment for birth services which is usually around $1800. The women must choose a Lead Maternity Carer (LMC) who controls the budget. If more than one person provides care then it is the LMC who must pay that person. So if, for example, the woman chooses a doctor as LMC, the doctor must pay the midwife for any care provided and they must negotiate that payment. If a midwife is LMC she must pay the doctor if one is involved in primary care. Currently in New Zealand midwives are the LMC for 53% of births (Guilliland, 1998). Midwives who work without a doctor may claim the whole fee. In MPOs these payments are claimed by the organisation's administrators and paid to the appropriate health professional. This has made shared care a much less lucrative option for midwives and has seen many general practitioners withdraw from maternity

care altogether. For women it has reduced their choices for childbirth as many find it difficult to find a doctor to provide maternity care. As a part of all maternity contracts now there are requirements for some evidence of quality assurance processes. The recording of outcomes is required, and peer review is mandatory.

The midwifery profession has continued to grow and develop. The NZCOM is now the recognised body representing midwives and is active and involved at many levels, politically and educationally. It has acknowledged its need to be accountable and responsible. Although there was no statutory requirement to do so, it developed in 1990 its own quality assurance mechanism. This is the Midwives Standards Review Process. It was based on the review process developed by the Home Birth Association and included the College's Standards for Practice as a tool for measurement. The description and development of this process is the subject of this study.

New Zealand now has both midwifery education for registered nurses and direct entry midwifery training to degree level at five technical institutions. It has post-graduate education to Masters and PhD level at Victoria and Massey Universities. The NZCOM has developed a model of midwifery, a Code of Ethics, Standards of Practice, Education and Service. It has a National Office in Christchurch and a staff of six.

None of these developments has come easily. There has been a very impressive backlash from the medical profession who have insisted without proof that midwifery care is expensive and unsafe. Midwives continue to struggle to maintain their profession and for adequate and equitable funding and for the protection of their education system. Of current interest is an eventual review of the Nurses Act which midwives hope will result in a separate Midwives Act and a separate Midwives Council. This Midwives Council would be responsible for the registration, regulation, and discipline of midwives.

My midwifery story

It has been a fascinating and enlightening time to be involved in midwifery. Twenty years ago I trained in Wellington as a midwife. Although I had completed my nursing education as a student at a polytechnic, midwifery was still, in 1976, a six month hospital based apprentice-type course. Birth as a medical, hospital, doctor controlled event was the dominant modus operandi. Since then I have been practising as a midwife, with small breaks to have three babies myself. Along the way I have worked in a large tertiary care hospital as a charge-midwife in the Delivery Unit, and in the postnatal and antenatal areas. I have been a home birth midwife, an educator, a perinatal unit manager, and am currently working as a midwife in an integrated primary health practice caring for low income families. My own personal philosophical approach to midwifery and to maternity care has also radically changed.

My transition from base-hospital delivery unit charge-midwife to home birth practitioner in 1988 came as a result of caring for women who were increasingly challenging the medical model, and working with a wonderful group of 'stroppy' midwives for whom I have a great deal of admiration and affection. The critical importance of evaluating and reflecting on my practice was set in concrete from this time. Stints as a manager in the middle of the Health Reforms were a sobering experience.

I also became very involved in the political battles of the time. I joined the Midwives Section of the New Zealand Nurses Association in 1983 as its Wellington Chairperson. We began the long struggle to retain midwifery in New Zealand. We had to battle on all fronts including that of the nursing profession. Among the more memorable incidents for me in that time was working with a midwifery colleague in Wellington on drafting the philosophy of the Midwives Special Interest Section of the NZNA, which was adopted almost in its entirety by the Section and remains today as the philosophy of the NZCOM. I was also the speaker who seconded and spoke to the Midwives Special Interest Section remit at the 1985 NZNA Conference which adopted the WHO

definition of a midwife. I was present at the Special Interest Section Conference in 1988 and proposed the motion at the end of the conference that we close the conference and reopen discussion as the New Zealand College of Midwives. I was subsequently the secretary of the working party that drafted the constitution of the fledgling College.

Since then I have retained membership of the College with varying degrees of active participation as babies and personal circumstances have permitted, and am currently the College's representative on the Accident Corporation Commission's Medical Misadventure Committee. I have also retained an active interest in and involvement with the College's Review process.

My interest in midwives review

Having worked as a midwife over the last 20 years it is hard for me to escape questioning what it means to be a midwife, what we are trying to achieve and why. Critical to this stage for me was the threat to midwifery's very existence. We had to examine what midwifery was all about and ask what made it worth preserving. For most midwives this was a new process. The task of reflection had begun. We had to justify our existence both to ourselves and to others. So we also had to prove that what we did was worth preserving. We had to be accountable. For many it was both a personal and political process. The social climate of the times facilitated this process.

The second wave of feminism, a growing consumer movement, and reforms to the health system all stimulated for me much reflection and challenge. As a new home birth midwife in Auckland in 1989 I had my practice reviewed by the domicilary Midwives Review Committee and learned of the value of personal reflection and review. With the establishment of the College of Midwives, and on my return to Wellington, I joined the sub-committee of the Wellington Region of the College which was looking at establishing a review process for the growing number of midwives who were practising independently. I participated in all the NZCOM national workshops looking at the development of the review process and co-ordinated the review process

in Wellington for the first year. Since then I have remained on the review co-ordinating committee and am used as a reviewer on the panels when a reviewing midwife is unable to attend. I speak to College meetings about the process and help with the education sessions for new reviewers. I continue to have my own practice reviewed.

I am then not a dispassionate, objective researcher of the process. Much of what I have experienced is in this study. I remain committed to the concept that if midwives wish to be autonomous they must practise in a manner which is both responsible and accountable. In order to achieve this, both reflective practice and some system of quality assurance process are imperative. The development of the review process has been both arduous and exciting. The aspect of the review process which has been the most innovative and rewarding has been the involvement of the consumer as an equal partner. This is unprecedented and sometimes controversial. Despite my involvement with the process I do however have some concerns about its aims and operations. It is timely now to evaluate it. It has been functioning long enough to be both described and challenged, which is what I propose to do in this work.

This thesis is divided into seven chapters. This opening chapter has provided a background to the study by describing the historical context in which the Midwives Standards Review Process has been developed. In Chapter Two I will describe the methodology of the thesis, in particular my journey through evaluation research towards my final choice, that of case study. Chapter Three will provide the detail of the research design using the case study methodology of Robert Stake (1995). The findings of the research will be presented within the report in Chapter Four. It will describe the development of the MSRP, the details of how it operates and how it is positioned within the wider health sphere. This chapter will identify issues of most relevance which will then be developed further in Chapter Five. Chapter Six will identify areas for further development and Chapter Seven will provide the conclusion to the study. Extensive appendices will be provided for those interested in the detail of the review process.

CHAPTER TWO: METHODOLOGY

In order to describe how my research into the midwives review process was undertaken it is important to look a little at the wider sphere of evaluation research so that my final choice can be placed more understandably within it. There are many models of evaluation research. It is a field which encompasses every type of research method and philosophical perspective. This chapter details the story of my journey through evaluation research towards the discovery of what became my final choice, the case study methodology of Robert Stake (1995).

Evaluation research

Patton (1990) defines evaluation research quite broadly as including *"...any effort to increase human effectiveness through systematic data-based inquiry. Evaluation is applied research"* (Patton, 1990, p.11). He goes on to distinguish between applied and basic academic research.

> *"The purpose of basic research is to generate theory and discover truth, that is, knowledge for the sake of knowledge. The purpose of applied research and evaluation is to inform action, enhance decision making, and apply knowledge to solve human and societal problems"* (ibid., p. 12).

Evaluation is a valuable undertaking in that it:

- *"Provides evidence of whether a programme is making a useful contribution.*
- *Provides useful and rewarding feedback which can re-energise and re-focus.*

- *Contributes to theory building.*
- *Establishes public accountability and demonstrates effectiveness.*
- *Demonstrates cost-efficiency."* (Palfrey, Phillips, Thomas & Edwards, 1992, p.13).

Modern evaluation has its origins in the 1960s. It emerged in the united States of America within the fields of both social policy and education. During this time large scale social programmes had been initiated by President Kennedy to help Americans suffering from the effects of poverty. Education had also been thrown into turmoil as the Russians launched into space ahead of the Americans, putting them in number two position. Americans wanted to know where their education system had gone wrong (Guba and Lincoln, 1981 p. 7). Over the last three decades there has been an enormous growth in evaluation as a theoretical entity and as an industry. It now encompasses most areas of social, professional and political life.

> *"Evaluators have emerged from the 20-year embrace more sophisticated about the complexity of their task and more realistic about the political realities that exist in social programs and about how social science information is used in social problem solving. Evaluators now find themselves addressing an expanded list of theoretical and practical issues most of which were identified as lessons learned from the earlier years of evaluation practice. Debates in the field have now acquired a remarkably catholic, interdisciplinary, and grounded character."* (Cook and Shadish, 1986, p.194)

However it is often not well regarded by academics who see it as being an impure form of research. (Filstead, 1979, in Cook and Reichardt, 1979, p.40)

Evaluation paradigms

Within the world of research there has been a long-standing debate about how best to conduct research. There has been a corresponding debate within evaluation research with much discussion about the most appropriate methodology. In the 1960's experimental methodology was the main focus. The early evaluation theorists, such as Campbell (1964), stressed the importance of rigorous scientific standards for judgement. By the 1970's disappointment was beginning to be expressed about the results of purely quantitative evaluation programmes. They were often seen as being ambiguous, providing an incomplete picture of the programme being evaluated, and as insensitive both to the political undertones and to the expectations of the stakeholders (Filstead, 1979, in Cook and Reichardt, 1979, p.39).

Researchers then began to advocate for the use of qualitative methodology. Theorists such as Stake (1978) for example, advised evaluators to use such methods as observation, inspection of records, and open ended interviewing. They proposed qualitative methodology with the same vehemence that had characterised their quantitative colleagues a decade before. Both factions based their choices within a particular paradigm of enquiry (Connor, 1981,& Shadish et al, 1991).

Michael Quinn Patton (1978) defines a paradigm as:

> *"...a world view, a general perspective, a way of breaking down the complexity of the real world. As such, paradigms are deeply embedded in the socialization of adherents and practitioners: paradigms tell them what is important, legitimate, and reasonable."*(p. 203)

The two different and competing paradigms are:

> *"Logical- positivism, which uses quantitative and experimental methods to test hypothetical-deductive generalisations, versus phenomenological inquiry, using qualitative and naturalistic approaches to inductively and holistically understand human experience in context-specific settings."* (Patton, 1990, p.37)

These paradigms are also referred to as the positivist and the constructivist paradigm. There is debate about whether methodological choice needs necessarily to be linked to paradigm, and that those methods which rely on a quantitative or qualitative methodology need not necessarily relate exclusively to their corresponding paradigm. They can both be used in the same piece of research (Cook and Reichardt, 1979, p.12-17). It is becoming more acceptable that *"neither method type alone is generally sufficient for all of the diverse requirements of evaluation research"* (ibid., p.19). This is especially true in evaluations where the research may have multiple purposes such as evaluating both the process and the outcome of a programme. (ibid.)

Patton (1990) prefers pragmatism to paradigm allegiance and proposes that an awareness of the paradigm debate is important mainly in that it frees researchers from methodological prejudices, enhancing methodological creativity and flexibility. He advocates a paradigm of choices which

> *"...recognises that different methods are appropriate for different situations. Situation responsiveness means designing a study that is appropriate for a specific inquiry situation. There aren't just two paradigm-dictated choices. All kinds of variations, combinations, and adaptations are available for creative and practical situational responsiveness* (ibid., p.39.).

This debate is still very much apparent, as policy makers and politicians continue to demand hard scientific data either to support or to reject a particular policy plan. The realities of the world demand that evaluators become much more sensitive and responsive in order to produce an evaluation that is both useful and used.

More recently there has been a growing discussion about the relevance of postmodernism to evaluation. As a paradigm there is a great deal of confusion about what postmodernism actually is. According to Rosenau (1992) postmodernists

> *"...criticise all that modernity has engendered: the accumulated experience of western civilisation, industrialisation, urbanisation, advanced technology, the nation state, life in the 'fast lane'. ...Where knowledge is concerned postmodernists challenge the disciplinary boundaries of modernity which can be construed as attempts to bring order to a disorderly world and celebrate the breaking of boundaries. There can also be a rejection of conventional academic styles of discourse in favour of audacious and provocative delivery"* (cited in Tones and Tilford, 1994, p.54).

For evaluation researchers the general support for methodological pluralism and diversity makes it inappropriate to make definitive statements about postmodernism. Suffice it to say it provides for a great deal of thought and discussion.

Theories of evaluation

This paradigm debate is reflected within the different theoretical approaches taken by evaluators. It is useful to look at the various theories of evaluation in order to place this piece of research within the wider context of the epistemological and ontological

debate. Cook and Shadish (1986) describe three theoretical approaches to evaluation. They are based on:

1. Identifying Manipulable Solutions. This theory assumes cause and effect and is interested in the extent to which solutions are effective. It uses such methods as randomised experiments and planned variation studies. It assumes that results can be transferable to another setting. This approach was dominant in the early years of social programme evaluation and used predominately quantitative methods.
2. Identifying Generalizable Explanations. Evaluators who use this approach believe that the world is ontologically complex so that a particular effect may be present under one condition but not others. They attend also to process as well as outcome, and prefer models which emphasise multivariate causality.
3. Providing a Stakeholder Service. These evaluators subordinate all other aspects of evaluation to the needs and interests of the stakeholders, be they managers, clients or service providers. The evaluator acts as a consciousness-raising educator, maintaining close contact with the programme so as to remain responsive to changing needs (pp. 225-7).

Models of evaluation

Models of evaluation proliferate and have been very creative in the ways they have attempted both to ask and to answer evaluation questions. Glass & Ellett, (1980) propose that attempting to define evaluation may inhibit its ability to be expansive and creative. They group evaluation models into areas distinguished by their different conceptual approaches.

1. Evaluation as Applied Science: The evaluator is seen as an experimenter, operationalising and measuring quantitatively.
2. Evaluation as Systems Management: This model sees social programmes as systems involving planning, implementation and testing. Evaluation must attend to each of these elements and is concerned with efficiency.
3. Evaluation as Assessment of Progress Toward Goals: With its basis in positivism, this conception of evaluation simply assesses whether goals have been met. It makes no value judgements about the goals themselves.
4. Evaluation as Jurisprudence. A more recent innovation, this is patterned after judicial procedures in which advocates for both sides are selected and made adversaries. Merits of both positions are put and a verdict is rendered.
5. Evaluation as Description: The programme is described in detail including its effects, expectations and judgements. It is often undertaken as case study using the methods of ethnography rather than experimentation. The processes and design of the evaluation are responsive, adapting as it progresses.
6. Evaluation as Rational Empiricism: No particular approach is put forward as prescriptive but the best evaluation design is a combination of the fundamental purpose of evaluation and the possibilities afforded by the situation. Within this approach there is no absolute formula for good evaluation (Glass & Ellett, 1980, pp.213-217).

Values, politics and ethics in evaluation.

Before going on to describe and develop my own methodological choice it is valuable to look briefly at the issues of value and ethics as they relate to evaluation research. These issues manifest themselves in different ways according to different paradigm allegiances. (Guba & Lincoln, 1989) In the early days of evaluation the positivist paradigm attempted to maintain objectivity and with it, value freedom. It proposed a value free external reality where facts remained unavailable for inspection, discussion or refutation. By assuming objectivity and value freedom to be true, the positivist paradigm also ignored the inherent political nature of the evaluation. It was inclined to be politically conservative, working to maintain the status quo. (ibid., p. 124) Continued development of quantitative research within evaluation has seen the development of a much more sophisticated understanding of the political nuances of the work.

The ethical risks of the constructivist or qualitative paradigm include the suggestion that face-to-face contact may make the subject vulnerable to violations of trust, and that there can be difficulty in maintaining privacy and confidentiality. The report may contain shadings of truth or misunderstandings. Within this paradigm stakeholders and research participants should have the right to correct erroneous information or to have direct quotations removed. This seldom happens. (ibid., p. 125)

Social programmes however are not value free. Neither are the evaluations of these programmes. Utilitarian ethical theories (doing the greatest good for the greatest number) compete with deontological theories (doing one's duty). What is important is

that good value theory states its priorities as to which kinds of values to study and why.

If evaluators use prescriptive valuing, then their work reflects a particular value approach, for example prioritising the interests of the disadvantaged. Those evaluators, on the other hand, who use descriptive valuing describe the values held by the stakeholders. Within Western society, which in general fosters pluralism of values, descriptive valuing is most often the approach used. This valuing though is often not made explicit in evaluation reports (Shadish et al, 1991, pp. 46-59).

It is clear that evaluation differs from pure research in the degree to which it involves political overtones. Evaluators are in general employed or contracted to do the work by organisations who usually have some interest in either the continuance or cessation of the evaluated programme. Evaluators may have little understanding of these undertones when they are asked to do the research. They will also have little control over the interpretation and use of the results. Rossi and Freeman (1982) describe evaluation research as more than the simple application of methods.

> *"It is also a political and managerial activity, an input into the complex mosaic from which emerge policy decisions and allocations for the planning, design, implementation, and continuance of programs to better the human condition* (Rossi and Freeman, 1982, p.27).

The ethical implications of any evaluation need to be addressed before undertaking the research. The practical ethics of evaluation involves such issues as withholding treatment from control groups, confidentiality, and whether the process of the evaluation will do harm or good. Glass and Ellett (1980) go further however and state

that an evaluation should be assessed as being potentially worthwhile before claiming tax dollars. It must be useful and morally justified as a whole.

> *Evaluation, of the contemporary professional type, is done largely out of faith. Considering that the interest and commitment to evaluation is widespread, it is surprising how little solid evidence of its value can be found. One need not appeal to romantic arguments against evaluation to raise doubts about it. Evaluations, whether good or bad in conception and application, will be useless if ignored or if used as a facade to cover political manipulation.* (Glass and Ellett, 1980, p. 225)

It may be either difficult or inappropriate for the evaluator to make explicit the political implications of the work. Ethical and value implications should however be overtly described to make the process transparent and honest.

Methodology choice.

It can be seen therefore that there are multiple ways of constructing my study and many questions to be answered. Would I undertake it as an evaluation? What methodology would I use? Whose model would I follow, or would I simply design my own? It was enormously helpful for me to work through the basic theoretical issues as I have described them above.

My initial interest in undertaking this work came from my own involvement. My aims were two-fold: to describe the process in some detail, and to make some assessment as to whether or not it was working well. My own position was that the Midwives Standards Review Process was innovative, exciting and potentially very powerful

either as a quality indicator or as an educative tool for midwives. Other health practitioners might possibly be interested in developing the model for their own review purposes. In order for this to happen, the process needed to be published. Publication would also enable midwives to further illustrate the accountable, responsible nature of their profession.

"Evaluate" seemed to be a word that had some connection with what I was trying to achieve. There was some discussion with peers and tutors about whether description could be considered as a form of evaluation or in fact whether evaluation theory would be relevant, as the Midwives Review Process is neither a social programme or social policy. My explorations into evaluation literature established that in fact evaluation theory had everything required within it both at a theoretical and practical level to provide a framework for my study.

As I worked my way through the evaluation literature I kept in mind the aims of my research:

- To give an historical account of the review process.
- To describe the current review system including its aims and functioning.
- To discover how participants feel about the process including its strengths and weaknesses and how they feel it should develop in the future.
- To explore the relationship between the review system and the current health structures.
- To examine any policy documents relating to practice review.
- To establish whether training or preparation is necessary or sufficient.

- To assess the adequacy of resources.
- To highlight any areas for development or improvement.
- To compare the system with any others which have been developed for review of independent practitioners.
- To identify issues to be developed or included in a national review.

Another aspect of my study was that because of its small size it was inevitably going to be limited in its scope and depth. I intended therefore that it should be able to be placed within the context of a much larger piece of research. This larger work could look at the Midwives Standards Review Process at a national level and be able to develop the issues in greater depth. In this sense then, this work could be developed as a pilot project, keeping its structure and methodology congruent with a larger piece of evaluation.

It became clear during my reading that my research fitted the qualitative framework. I certainly intended to provide a holistic understanding of the review process as it exists within its social and political context, and to explore some aspects of the experience of the review from the participants' perspective. Quantitative data may be able to be explored in the larger study but this will not necessarily exclude the methodology that I intend to use. As stated earlier, diverse requirements of evaluation sometimes require that a mixed methodology be used.

Within the theoretical groupings of evaluation I would consider that my research comes within that of "providing a stakeholder service". I would certainly hope that my study would be of value primarily to many of the stakeholders I have interviewed, be it

the College of Midwives, health authorities or those involved in the review as reviewers or reviewees. The model I intend to focus on comes into the grouping of "Evaluation as Description". These studies are often undertaken as case study and are responsive to the situation and the issues presented. I certainly intended to describe the process in detail and to develop the relevant issues.

In evaluating the midwives review process I used a mixture of evaluation theories and tailored them for this purpose. Any programme exists in its own unique environment which includes political considerations, key stakeholders, economic constraints, aims and objectives. It is essential that the evaluator recognise this in the design of the evaluation. No one model of evaluation was entirely appropriate so I used the three most appropriate theories and produced a framework which matched my task. The theorists I used are Wholey (1977) who discusses evaluability assessments, Parlett & Hamilton (1976) who describe illuminative evaluation, but most importantly, Stake (1995) who uses a case study approach.

Evaluability assessments are designed to provide a climate favourable to further evaluation work and to acquire knowledge with a programme that would aid in evaluation design. They can also reveal whether or not implementation corresponds with the aims and objectives of the programme. In general the following steps are taken as described in Table 2:1.

Table 2:1 Steps of Evaluability Assessment (Rossi & Freeman, 1985, pp.89-90)

- "Preparing a Program Description. This description is based on formal documents. It includes statements identifying program objectives and cross-classifying them with program elements or components. The program description compares how the intervention is supposed to operate with how it actually works.
- Interviewing Program Personnel. Interviews are conducted with key people in order to gather descriptions of the program's goals and rationales, as well as to identify actual program operations. From this information, models of both the intentions and the actual operations of the program are developed and subsequently verified with persons interviewed.
- Scouting the Program. Site visits to obtain first-hand impressions of how programs actually operates.
- Developing an Evaluable Program Model. The program elements and objectives to be considered for inclusion in evaluation plans are explicated.
- Identifying Evaluation Users. Key Stakeholders are identified.
- Achieving Agreement to Proceed. The evaluation plan is reviewed with the key stakeholders"

This aspect of the study is important as I place my study potentially within the broader framework of a substantially larger piece of work. It will be important to keep account of what may be better developed further and to facilitate this process as I proceed. When conducting evaluability assessments, the evaluator assesses various potentials for further evaluation. In this sense my study could be seen by any future evaluator as a pilot study. Wholey's model is however quite focused on the eventual evaluation of outcome achievement and successful meeting of objectives. This is not the central aim of my study.

Illuminative evaluation is used for innovative or developing programmes. It provides for intensive study of the programme as a whole, and it relies almost entirely on qualitative data collection techniques. (Table 2:2)

Table 2:2 Questions for Illuminative Evaluation (Green & Lewis,1986, p.162)

- "How does the program operate?
- How is the program affected by various situations?
- What do program personnel consider the program's strengths and weaknesses to be?
- What is it like to be a program participant?
- What are the most significant features of the program?
- What do the primary effects of the program appear to be?"

The College of Midwives Standards Review Process is an innovative process which does not appear to have been undertaken elsewhere, either in New Zealand or internationally. It certainly warrants close description.

Case study evaluation

The model on which my study will be principally based is that of case study. The particular case study approach I used was developed by Stake in 1975 and further refined by him in 1995 in his book "The Art of Case Study Research". Stake was the evaluation theorist largely responsible for the introduction of qualitative methodology onto the evaluation scene.

Case studies are expected to catch the complexity of a single case and are particularly valuable where the case is of very special interest. Stake organises his studies around issues and proposes the use of *'naturalistic, holistic, ethnographic, phenomenological, and biographical research methods'* (Stake, 1995, p.xi). A case may be studied for its intrinsic interest or as an example to understand a wider issue. Case studies emphasise interpretation rather than generalisation. The particular characteristics that make it different from other research methods are outlined in Table 2: 3.

Table 2:3 Features of Case Studies (derived from Guba & Lincoln, 1981, pp. 375-6, and Stake, 1978, cited in Shadish et al, 1991, p.63)

- descriptions are complex, holistic, and involve a myriad of not highly isolated variables
- data are likely to be gathered at least partly by personalistic observation
- a writing style that is informal perhaps narrative, possibly with verbatim quotation, illustration, and even allusion and metaphor
- comparisons are implicit rather than explicit
- themes and hypotheses may be important, but they remain subordinate to the understanding of the case
- it provides "thick" description, allowing the reader an understanding of how the case could provide insight or development in their own settings
- it is grounded, providing data that emerges from the setting itself rather than from an external hypotheses
- it is holistic and lifelike, being easy for the reader to become involved in
- the data are simplified, avoiding complex technical details
- the reader is presented with a well integrated statement, assisting him/her in the illumination of meaning
- the case study builds on the tacit knowledge of the reader, communicating more than can be said in pure technical language

Data gathering

Data gathering begins when there is commitment to do the study, even before, if the researcher has had some involvement in the process. What is critical is the attentiveness and experience of the researcher. There needs to be a gathering plan which allows for unanticipated data sources or emerging issues. It needs to be a plan rooted in the research questions. Essential elements of the data gathering plan are: *"definition of case, list of research questions, identification of helpers, data sources, allocation of time, expenses, intended reporting"*(Stake, 1995, p51). The principle methods of data collection are: observation, description of contexts, interview, and document review.

Data analysis.

Within case study, there is no particular moment when data analysis begins.

> *"This is case study, not general qualitative research. With intrinsic case studies, our primary task is to come to understand the case. It will help us to tease out relationships, to probe issues, and to aggregate categorical data, but those ends are subordinate to understanding the case. The case is complex, and the time we have for examining its complexity is short. To devote much time to formal aggregation of categorical data is likely to distract attention to its various involvements, its various contexts. Usually we will try to spend most of our time in direct interpretation."* (ibid., p. 77)

"In my analysis, I do not seek to describe the world or even to describe fully the case. I seek to make sense of certain observations of the case by watching as closely as I can and by thinking about it as deeply as I can. It is greatly subjective. I defend it because I know no better way to make sense of the complexities of my case." (ibid., p. 76)

Within Stake's model the search for meaning is often the search for patterns. The most critical data may be coded, but if there is little time the pattern or significance may be found by direct interpretation. Often the patterns will have been developed in advance, drawn from the research questions, acting as a template. Occasionally, patterns will emerge directly from the analysis.

The purpose of case study is to make the single case understandable. The study of a single case is not as strong a base for generalisation to other cases as may be produced by other research methods but the reader can learn much from a single case. It can build on previous experience. Stake calls this 'naturalistic generalisation'.

"Naturalistic generalisations are conclusions arrived at through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves." (ibid., p. 85)

The purpose of the study then is to assist the reader's vicarious experience. Readers can often be more familiar with the case than the researcher is. They can add their own parts to the story. Other readers bring their own knowledge and

experience to the story. To help the reader then to make these naturalistic generalisations, vicarious experience should be enhanced.

> *"Our accounts need to be personal, describing the things of our sensory experiences, not failing to attend to the matters that personal curiosity dictates. A narrative account, a story, a chronological presentation, personalistic description, emphasis on time and place provide rich ingredients for vicarious experience."* (ibid., p.86-7)

Case researcher roles

Stake goes on to describe the various roles the researcher can play stressing that he/she has options as to how they will be played. The roles may include: " *teacher, participant observer, interviewer, reader, storyteller, advocate, artist, counsellor, evaluator, consultant and others* (ibid., p. 91). The evaluator needs to contemplate the implications of role choice. Different roles may work better for certain people and in certain situations.

Triangulation

Reliability and validity are important in case study as they are in any research undertaking. Within qualitative inquiry triangulation is the protocol often used. Stake proposes five methods of triangulation:

1. Data source triangulation. Does the case remain the same at other times?

2. Investigator triangulation. Does a different researcher come to the same conclusion?
3. Theory triangulation. Do co-observers from alternative theoretical viewpoints confirm similar findings?
4. Methodological triangulation? Do different methods of data collection confirm findings?
5. Member checking. Do participants confirm that the findings are accurate representations? (ibid., pp. 107-115)

The written report.

Stake makes a strong case for ruthlessly *'winnowing and sifting'* the report so that the reader is *"neither burdened with the presumable nor denied the grounds for assumption."* (Stake,1995, p.127) The report needs to be written with the reader in mind and should not be long. Stake's example of a possible structure is described in Table 2: 4

Table 2:4 Stake's Example of Case Study Structure (Stake, 1995, p123)

- Entry vignette - the reader immediately starts to get a feel for the case
- Issue identification - how the study came to be and who the researcher is
- Extensive narrative - straight description
- Development of issues - somewhere in the middle - a few key issues
- Descriptive detail - documents, quotations, triangulating data
- Assertions, information allowing readers to reconsider assertions, summary of what the researcher feels
- Closing vignette - on an experiential note, reminding that this is just one person's encounter with a complex case

He stressed that *"...the traditional research report of statement of the problem, review of the literature, design, data gathering, analysis, and conclusions, is particularly ill-fitting for a case study report"* (ibid., p. 128) The above proposed structure is simply an example of a possible report structure. Again the researcher is left to create her own. It becomes apparent that constructing a case study is indeed an art.

The development of my methodology therefore has followed my journey through the literature. My initial beliefs about the possible value of the Midwives Standards Review Process for both midwives and other health practitioners, and my early questions about its effectiveness, led to evaluation as a concept. Within the discipline

of evaluation research I discovered then that a myriad of models was available. It was finally Stake's approach which was clearly the most appropriate. It allows me to describe the review process in some detail and develop the issues while at the same time allowing my own voice to be heard.

CHAPTER THREE: RESEARCH DESIGN

Introduction

This research is a descriptive study of the New Zealand Midwives Standards Review Process in Wellington using three qualitative approaches; case study, illuminative evaluation and evaluability assessment. As the midwives review process is an innovative programme, the questions asked in the illuminative evaluation seem entirely appropriate (Table 2:2). I also intend that the research will be able to be used as a basis for a more extensive national evaluation so will include those aspects of evaluability assessment relating to further evaluation. Stake's (1995) model of case study permits the use of personalistic reporting which I find appealing especially given the intimate nature of reflective practice found within the Standards Review Process. It also allows me to report some of the comments verbatim. Given also that I have such a high level of involvement it will allow me to make this more explicit in the reporting. This study is essentially a descriptive one, yet any description inevitably involves some aspect of evaluation. What I intend to do is close to what is termed process evaluation which measures the activities of a programme and assesses its quality, as opposed to impact or outcome evaluation which measures the immediate and long term effects of a programme. (Hawe, Degeling, & Hall,1993, p.60)

The study could be described as a review of a review or an evaluation of an evaluation. The language could get extremely confusing so it will be important to be careful about this. For this reason I will refer to this study as 'the evaluation' and to the midwives review process as 'the review'. The structure of the design is represented below.

Table 3:1 Number of interviews/observations

NZCOM	Permission to conduct the study Interview with the Director Interview with Midwifery Advisor Examine documents
Key Informants	
Joan Donley	Interview
Marjet Pot	Interview
2 Crown Health Enterprises	Interviews Examine documents
Regional Health Authority	Interview Examine documents
Local co-ordinator	Permission to observe review and approach members Interview taped (possibly 2) Examine documents
2 Reviews	Observe Tape-Analyse
Midwife 1 (Cathy)	Interview Tape- analyse
Midwife 2 (Pat)	Interview Tape- analyse
Reviewer 1 (Consumer, Chris)	Interview Tape- analyse
Reviewer 2 (Midwife, Pauline)	Interview Tape- analyse

Study participants

Those participating in the research will be:

- **The National College of Midwives**:

I intend to conduct open ended interviews with Karen Guilliland, the National Director of the NZCOM and Bronwen Pelvin, the midwifery advisor officer of the NZCOM. These interviews will take place in Christchurch where the College office is based. Areas to be covered in the interviews will be: the history of the process, aims and objectives, difficulties, issues, plans for the future. Documentation will be examined to further develop a picture of the review process's development and aims. This includes policy statements, minutes of meetings, and letters.

- **Two Key Informants**

I intend to interview Joan Donley and Majet Pot about their involvement in the review process. Joan Donley has had extensive involvement in midwifery, specifically from a home birth perspective, and has been New Zealand's leading midwife in the fight for midwifery autonomy. Her involvement in the development of the NZCOM has been pivotal. Majet Pot comes from the consumer perspective and has been an active participant in both home birth and College activities, specifically in the development of the review process.

I will interview them in their homes in Auckland. Areas to be covered in the interviews will be: the history of the process, aims and objectives, difficulties, issues, plans for the future.

- **The Central Regional Health Authority, Capital Coast Health and Hutt Valley Health Crown Health Enterprises.**

The maternity managers at two Crown Health Enterprises (hospitals) in Wellington will be interviewed, as well as the maternity services officer of the Central Regional Health Authority (the health funding agency) I intend to discuss the Midwives Review Process and any quality requirements that they have at present or are likely to have in the future.

- **The Wellington co-ordinator of the midwives' review process.**

I intend to interview the Wellington co-ordinator, Rae Clarke. As I am part of the Wellington review committee I already have a working relationship with her, so the interview will consist of a refocusing and clarification of the issues. Topics to be covered include

1) Describe the process. How does it function?
2) Why does the process exist?
3) How has it evolved in Wellington?
4) What are some of the difficulties you have?
5) What resources do you have and are they enough?

6) How are the panels chosen and how are they trained?

7) How many midwives use the process?

8) Do you receive any feedback about the process?

9) How do you see the process developing in the future?

I will obtain copies of any documentation used in the review process.

Methods

- **Observation of a review.**

I intend to observe the reviews of two midwives. This may occur during the middle of the year. Both these midwives are being reviewed for the first time. I will not participate in the reviews. The reviews will be taped and I will take notes about the physical environment, body language, interpretation and any issues that arise which may need further clarification. The tape recording will be used to analyse time spent on various aspects of the review such as goal setting, discussion on standards of practice, education, outcome evaluation, personal support, group practice, difficulties experienced, and aims for the coming year, and to identify issues for further clarification in the interviews.

- **Interviews with the reviewed midwives.**

During the following weeks I will interview the two midwives. The interviews will be taped and notes will be taken. Questions in the interview can be divided into three areas:

1) Interpersonal issues - Did they feel comfortable being reviewed? Did they feel free to be open about their practice? Was it a threatening experience or did they feel supported and encouraged?
2) Service issues - Did they feel that the review was well organised and that the reviewers were well prepared? Was it an efficient use of the time? Was the

preparation for the review sufficient? Did they need any help in the preparation for the review?

3) Content issues - Why did they choose to be reviewed? What did they get out of it? What was the best thing about it? What didn't work? Would they choose to be reviewed again? Would they recommend the review to other midwives? Did they feel sufficiently challenged? Will it change their practice? Did they think the reviewers had a thorough understanding of their practice?

- **Interviews with reviewers.**

During the following weeks I will also interview two of the reviewers to gain their perspective on what the review means to them. One of the reviewers will be a midwife, and one a consumer representative. The interview will be open ended and have the following guideline:

1) Interpersonal issues. How does the review panel work as a team? Do you feel able to challenge the midwife in areas that you think are of concern?
2) Service issues. Did you feel well prepared to be a reviewer? Do you get enough information and enough time to prepare for the review? How much time does it take? Is this too long? Do you have expert assistance if you require it? Do you know what to do if a difficult situation arises?
3) Content issues. Do you think you get a good idea of a midwife's practice? Do you feel that you make a contribution to her practice?

Data analysis

I intend first to describe the New Zealand context, then to describe the process as it proceeds. While doing this I will begin to identify the issues around midwives review as they are presented by the participants and as they become apparent to myself. Within Stake's model the case study is not just about simple description but involves some identification and exploration about the issues most relevant within the case. This facilitates the readers understanding about the life of the case including what are its difficulties and challenges.

As the study is principally a descriptive one, the data will be gathered from all sources and sorted into a logical sequence of presentation, to give some sense of the flavour and ambience of both the situation in New Zealand and of the review.

I will not rely on coded data but on interpretation directly through observation and on my experience. As this is case study, not general qualitative research, formal aggregation of categorical data will be overshadowed by direct interpretation and narrative description. I do not therefore intend to categorise data

Reliability and validity

As stated earlier, triangulation is the method of choice for maximising reliability and validity. Of Stake's five methods of triangulation I was able to make use of three.
I observed the reviews of two midwives not only to gain a better picture of what the reviews looked like but also to ensure that there was some consistency between the two. My own prior experience of review was also used to ascertain that indeed these two reviews were consistent with what usually happens. During the four interviews I conducted with the NZCOM officers and the key informants, I was able to ask many of the same questions about the origins and purposes of the standards review process. This aided in confirming my findings. This was data source triangulation.

Methodological triangulation was obtained by using different methods of data collection, specifically: interview, observation and examination of documentation. Member checking was obtained by asking those interviewed to confirm that the findings chapter did in actual fact represent their experiences. I was not able to use investigator or theory triangulation due to the size and nature of the study.

Stake's proposal that the report should not be long and that it should give the reader a good feeling for the case has implications for the way in which I decide to write up my study. For case study reports, especially following Stakes ideas, the picture that the report paints is important and superfluous information will detract from this picture. For the purposes of this study then, not all data gathered will be detailed within the body of the report but may be provided in appendices. Some data gathered will not be used.

There will be readers of the study who are very familiar with the review process and others who know nothing about it. Some may be midwives in NZ who want to see it developed. Others may include health practitioners from other disciplines or midwives from other countries wanting to look at models of quality assurance. To some degree the report must attempt to meet the needs of most readers. For this purpose there is some relevance in placing the review in its historical context. It would be much easier for the novice reader to understand the review process when it is placed within the New Zealand context.

Within the description of the reviews which may include narrative or direct quotation there will be some merging of the two midwives' experiences to protect their anonymity.

The report will be a mixture of facts as collected but will also see the beginnings of issue identification and my own comments on these. Detailed development of these identified issues will be covered in the section following the report. Findings are not therefore presented in isolation from discussion as happens in most research reports.

Ethical issues

Ethical approval.

Ethical approval for the study was obtained from both the Wellington Ethics Committee of the Central Regional Health Authority and the Ethics Committee of Victoria University of Wellington. (Appendix 6)

Confidentiality and informed consent

The issue of confidentiality and anonymity applies principally to the reviewed midwives and to the reviewers. There were approximately 20 midwives reviewed in the Wellington area during the year of my study and there are about 16 reviewers. The names of those four in the study will not be mentioned nor will any identifiable situations be related. The taped review will be kept secure in my home and will be erased at the completion of the study. None of the participants wished to have the tapes given to them. Written informed consent was obtained. (Appendix 6) Information included a description of the study and an outline of how the information gained would be used. (Appendix 6) I have provided those interviewed with a copy of that part of the report which included comments made by them or which related details of the interviews for verification and permission to use.

For the officials within the two CHEs and the RHA, the issue of confidentiality presented somewhat differently. Although I haven't used their names, they are all known officials and thus could easily be identified. For this reason I sent them also the relevant sections in the report for permission to use them. For those named in the report I obtained written permission to interview and to identify them within the report and again obtained permission to use the relevant sections in the completed report.

Role of the researcher

I am very aware that I have considerable involvement and interest in the development of the review process and it was of concern to me that because of this I may not be the best person to evaluate it. Issues of objectivity were apparent early in the planning of this work. This was one of the reasons why I chose the case study methodology of Stake and why I have been careful to state my position very clearly.

Evaluation is an inherently political activity and this study will be no exception. Evaluation has a political stance and sends out political messages. The politics of evaluation requires evaluators to recognise the existence of multiple interests and incorporate these into the evaluation. (Palumbo, 1987) No evaluation can be objective and the information elicited can be used by anyone to support or negate a particular point of view. Information is power. Evaluators should avoid producing only that data which supports one particular position. This is important in my study which I intend as being a useful way of illustrating the high quality and professionalism of

midwifery care. I must be careful not to overlook any of the difficulties or problems inherent in the review process.

Ownership of the research

The NZCOM Midwifery Standards Review Process is the property of the College. I also consider that the information gained in the study is primarily the property of the College. The completed report will be sent to the College for acceptance and approval to publish. I feel this is vital as it would be naïve to suppose that evaluation can never be used in a negative sense by those opposed to the programme or to those involved in establishing it. Of great importance to me is the fact that I do not wish to harm the midwifery profession in New Zealand.

CHAPTER FOUR: THE REPORT

This section gives a picture of the Midwives Standards Review Process (MSRP) as it currently exists. At the beginning of this work I discussed the New Zealand midwifery story. The first part of this chapter begins by describing how the MSRP evolved within this midwifery story. The issues begin to become apparent. The central section looks at the process itself. It presents the story of two reviews from the perspectives of both the two reviewed midwives and two of the reviewers, one a midwife, the other a consumer representative. Some of the evolving issues are discussed with these interviewees and are reported from the observed reviews.

The third section looks at the MSRP from behind the process. It looks at how the reviews are co-ordinated at a local and national level and how they fit within the wider health sphere. And finally I will look at other models of professional practice review and at how the MSRP compares on both a national and international front. These sections also look at further identification and elaboration on the developing issues.

Data collection followed the research plan. I observed the reviews of two midwives and interviewed them both soon after. I also interviewed a midwife reviewer and a consumer reviewer from those reviews that I had observed. I met with the local co-ordinator, obtained the relevant documentation and discussed her role and concerns. I visited the New Zealand College of Midwives (NZCOM) National Office in Christchurch and interviewed the National Director and Midwifery Advisor. While there I looked through the NZCOM's documentation relating to the MSRP. I visited

two key informants in Auckland Joan Donley and Marjet Pot and interviewed them both. I interviewed representatives of the local hospitals and the health funding agency and made contact with the New Zealand Council on Healthcare Standards, the New Zealand College of General Practitioners and the New Zealand College of Physiotherapists.

This chapter, then, aims to provide the reader with an holistic understanding of the MSRP through historical overview, situational placement, vicarious experience and comparative study. Throughout, findings and interpretation are interwoven to assist the reader's ability to make naturalistic generalisations. The aim is also to assist the reader discover as I did the origins of the key issues. These issues are found within the areas of quality assurance, reflective practice, supervision and competence assessment and include such questions as:

- Can quality be assured?
- Should a pass/fail point be applied?
- How can professional development be facilitated?
- Can professional performance be controlled?
- What system facilitates reflection?
- Are quality assurance and reflective practice mutually incompatible?
- How autonomous can midwives be when working to set standards?

The establishment of the review process

The New Zealand home birth movement

Much of midwifery growth and development in New Zealand has its origins within the home birth movement through the action both of its midwives and its consumers. Midwifery review is no exception. As mentioned in Chapter 1, home birth in New Zealand was, by the 1980s, an option that an increasing number of women were choosing. Local Home Birth Associations were formed in NZ in the late 1970s and the National Home Birth Association was formed in May 1980. In the fight to maintain and encourage the home birth option it was this group of people who were most active in the challenge to the medical, patriarchal model of birth. They developed acute and effective political skills to fight the battles with the obstetric institutions and the political infrastructure. They were forced to develop strategies for survival. They were the people who initiated and led the forces for challenge and change. And it was this group who learnt that their efforts could be more effective by combining their efforts. The concept of partnership, central now to the College of Midwives philosophy, had its origins here.

There was a corresponding increase in the hostility and reactivity expressed by the health officials who were pressing for increased medical control and centralisation of maternity services. The New Zealand Nurses Association released its "Policy Statement on Maternal and Infant Nursing" in 1981 and the Department of Health its

"Mother and Baby at Home; The Early Days" in 1983. Both documents proposed strict requirements and controls for domicilary midwives with an undertone of strong disapproval for home birth as a viable option. They were recipes for the end of home birth. For example, "Mother and Baby at Home" recommended that home birth practice should come under the jurisdiction of hospitals. Up until this point domicilary practice was not under the jurisdiction of the hospital system but under the supervision of the Principal Public Health Nurse acting as the agent of the Medical Officer of Health. This had occurred due to an oversight. Prior to 1990, domicilary midwives had a contract with the Department of Health. This contract was signed by Peter Fraser, the Prime Minister in 1939! When the Department of Health handed the responsibility for maternity care over to the Area Health Boards in 1985 they neglected to include the domicilary contract in the hand over, probably as there were so few. This provided domicilary midwives with some much needed autonomy as the reaction against home birth grew. It meant that the hospitals had no statutory right of control of home birth practice.

This push for strict limits and controls on home birth practice was strongest in Auckland and it was the Auckland domicilary midwives and Home Birth Association who resisted it so strongly. When hospital midwives were put on the Auckland Obstetric Standards Review Committee in preparation for controlling the practice of domicilary midwives in the area, it became apparent that immediate action was necessary. This policy was never enacted and it was the Home Birth Association which was largely responsible for its demise. In the battle for survival it became apparent to the Home Birth Association that if review and control of home birth

practice was inevitable then it would be important to get in and do it proactively. Better that it be done 'by' them than 'to' them.

Domicilary review

It was Joan Donley an Auckland domicilary midwife and birth activist who proposed that the Home Birth Association get in first to review domicilary practice. This would pre-empt these local hospital structures. Midwives and consumers within the organisation got together and prepared a review mission statement. They presented it to the Health Department for comment but received no response. They took the proposal to the National Home Birth Association Conference in 1986 for approval. A pilot project went ahead. Further correspondence with the Health Department continued to receive no response. The Home Birth Association decided to proceed anyway. By 1987 the reviews were underway.

The original committee in Auckland consisted of eight people, an equal number of professionals and consumers. There were four consumers, the Principal Public Health Nurse, a home birth doctor, a home birth midwife, and a midwife from the hospital. From its beginnings the commitment to equal standing for consumers in partnership was entrenched. Following midwifery autonomy the Principal Public Health Nurse had no jurisdiction over home birth practice so she was not included in reviews. The doctor's position was also disestablished the following year.

The committee reviewed around eight midwives a year for the following five years. It progressed smoothly, developing and modifying the review tool as it went. At her

review the domicilary midwife was required to present a written summary of her work, including the number of births, detailed information about transfers, difficult cases and any education undertaken. The review committee also provided a support role for midwives who had had a poor outcome, and provided a trial run for these cases which were proceeding to a Nursing Council hearing.

Within two years of its beginning every Home Birth Association in New Zealand had a review up and running. Each Annual National Home Birth Association Conference discussed and modified the process. It aimed to establish home birth practitioners as responsible, accountable professionals. It also aimed to provide a check on the growing number of home birth practitioners, to make sure that they were practising to the home birth ethic.

Home birth practitioners up until this point practised with a policy of low intervention. The routine use of oxytocics, Vitamin K for the neonate, artificial rupture of the membranes, pain relief, episiotomy and suctioning of the baby were all frowned upon. So too was the application of restricted time allowed for the stages of labour. All these were in general still routine in hospitals. The Home Birth Association, both midwives and consumers, were concerned that the growing number of midwives leaving hospital practice to become domicilary midwives would be practising 'hospital obstetrics' in the home. This they saw as dangerous. They were also concerned that home birth consumers using the services of these inexperienced midwives had a high incidence of transfer to hospital. Reviews in these early years were often a way of controlling and supervising these midwives. For new domicilary midwives, review could be a gruelling experience.

NZCOM review process

The 1990 changes to the Nurses Act which I described in Chapter One returned autonomy to midwives and put them on the same funding structure as doctors. This resulted in an influx of midwives out into the community to practice "independently". The Act enabled midwives not only to provide continuity of care without medical supervision but also to work with doctors and obstetricians in a shared care arrangement. In this shared care arrangement both doctors and midwives were able to access the Maternity Benefit for payment. In effect this benefit was being paid out twice for the same birth. What became of greater concern was that some midwives did not provided continuity of care but provided labour care only with the potential for earning a huge income. It was possible for a midwife who worked like this to receive $200,000 a year. This was due to the fact that the Maternity Benefit payment schedule, developed prior to midwifery autonomy, had been heavily weighted for the birth with a 'prolonged attendance' fee for doctors who were required to stay longer than one hour. Midwives who now attended the entire labour and birth could claim this fee. They could easily be at a birth 12 hours or more and were able to make a claim as 'prolonged attendance'. This was where the money was.

This practice horrified midwives and consumers who were committed to continuity of care and to home birth. They saw it as putting the whole battle for midwifery autonomy at risk. Negative publicity was not what was needed and the doctors used this practice to illustrate why midwives shouldn't have autonomy. From my

experience it was in the main these midwives who had shown little or no interest in the struggle for midwifery autonomy. It became apparent at this stage that midwives were not subject to any system of accountability, of peer review or of quality assurance.

By 1991 the Auckland home birth midwives review committee had also become aware of the first complaint made against an independent midwife. The hospital had approached the midwife directly about what they felt was inappropriate care. This, along with the committee's concern for the lack of continuity provided by some midwives, prompted it to discuss the possibility of extending the review process to include all self-employed midwives not just those providing a home birth service. They set up a working party and over two months developed a process for independent midwives who cared for women having hospital births.

The midwives who had been very involved in setting up the home birth midwives reviews were also very involved in the College of Midwives and it seemed a natural progression that the process should be adopted by the NZCOM and that it should be extended nationally. By 1993 the College of Midwives had become involved in the management and development of the process. The first committee was developed in Auckland and was called the 'Interim Midwifery Standards Review Committee'. By 1994 the 'interim' was dropped from the title. Initially in the Auckland area home birth midwives were reviewed by a separate review committee. These separate review processes continued in Auckland until the end of 1995. The MSRP committee was very proactive in getting all independent midwives reviewed. The reviews at this stage were principally concerned with monitoring and controlling practice, often giving quite

clear messages that some aspects of practice were unacceptable. They were often seen by the reviewed midwives as having an alternative or home birth philosophy.

Review committees were then started in all regions in New Zealand. Regional NZCOM subcommittees were established to develop the reviews in their areas. Initially each area developed its own tools and procedures but from 1994 annual national workshops were held to develop and standardise the process and to clarify its aims and objectives. Critical decisions along the way included: adding the NZCOM Standards for Practice, separating out the complaints from the review process, and merging the reviews of home birth and hospital practitioners into the one process. It began to be seen that the midwifery model as articulated in the NZCOM's philosophy and Standards for Practice applied to all midwives whether they worked at home or in hospital, and whether they worked in a shared care or midwifery-only care arrangement.

At the 1998 National Workshop it was confirmed that the reviews were to be seen as a tool for professional development, education and support. The NZCOM's Standards were clearly seen as standards of excellence, not of minimums. and thus could not be 'met' in any traditional sense of the word. There was not to be a pass/fail point. This idea runs contrary to current ideas on standards in which standards are considered the essential tool by which a professional is judged and where some measurable point of acceptable practice can be developed. To this extent the standards, which were developed in the early 1990's in the first flush of midwifery autonomy, may themselves need to be reviewed. This is acknowledged by the NZCOM which has found some

difficulty in having standards which call for perfect practice especially where disciplinary action has been taken against its members.

Thus the review process does not attempt to guarantee fitness to practice, but simply states that the midwife has voluntarily submitted her practice for review. It was confirmed that the MSRP would continue to be voluntary thus facilitating midwives' ability to be open and honest. The feeling that this was a 'home birth' process was no longer present. There was a real sense for the first time at an annual meeting of unity and clarity about the process and its purpose. It seemed as if MSRP had come of age.

How the process works

This section looks at the reviews of two midwives, Cathy and Pat, and describes the review in detail. Data was gathered from direct observation, interview and document analysis. The others whose comments I use in this section include Chris, a consumer panel member and Pauline, a midwife panel member. These names and other identifiable details have been altered to protect confidentiality. I have also included discussion with Rae the local co-ordinator.

Examples of a fictional completed review tool are provided throughout as tables to assist the reader's vicarious experience of the process. These examples are drawn from the training document provided for panellists. Background details and discussion are provided as appropriate and as the issues begin to become apparent.

The midwives

Cathy works in an urban low income area. Most of the families she cares for are poor and are of Maori or Pacific Islands descent. She shares the maternity care with their local doctor. This means that she alternates the antenatal visits with them and calls them to be present at the birth, but they are not usually involved directly in postnatal care. In most shared care arrangements the doctor plays the major role in the decision making process and is identified by the woman as the most significant health care provider or Lead Maternity Carer (LMC). Pat, on the other hand works in a more rural setting. Many of the women she cares for are also poor but most of her mothers are Pakeha (of European descent). Pat also usually shares care with the local doctors but has a growing number of women who choose not to have medical involvement in their births. Both women have been midwives for many years. Cathy returned to midwifery about ten years ago and has just completed her first year as an independent midwife in the community. It has been a big step for her. Pat's practice in the community is well established. She usually gets her referrals from the local doctors but is getting a growing number of women who come directly to her by word of mouth. They both have grown up children and supportive husbands to back them up so feel much more flexible to be able to meet the demands of the women under their care. Neither midwife has a structured group practice which would allow for regular time off so they spend a large amount of their time on call. Both do have midwife colleagues

who will help when needed. They are busy, hardworking and committed, and feel a great deal of satisfaction, challenge and enjoyment from their work. They are both members of the local College of Midwives and were aware of the review process. There had been frequent mention of it in College newsletters with strong encouragement for midwives to have their practice reviewed. Both midwives felt some pressure to be reviewed.

Cathy waited till she was approached directly from the review coordinator.

> *"I was given an appointment and a time. I had been a bit cowardly about venturing into it and thought I'd wait until someone decided to ask me so I didn't put myself forward. I just got a letter from Rae* (Appendix 1*) and decided no time like the present, so I'll do it. I knew they had some home birth consumers on the panel who would probably not approve of my way of working in shared care and in the hospital".*

Several of Pat's colleagues had been reviewed and she had felt some of the pressure to be reviewed herself. She commented:

> *"From the College's point of view we do have to have a standard. A standard can always be set in a book which is fine but it needs to be measured in a more physical form of what it is you're doing and how you are doing it and what problems you are coming across and how you have managed those problems."*

The review process in the Wellington area is voluntary. About 25 of the 70 practising independent midwives in the Wellington area are currently having their practice reviewed. Across New Zealand from region to region this proportion of midwives being reviewed differs considerably. This may be because of the roles and membership of the local NZCOM organisation, and possibly because of relations with the local

hospitals or even the perception in the area about the philosophy of the review committees. As Cathy stated:

> *"I thought there might be more criticism of my more conventional approach to midwifery."*

The coordinator feels some frustration that the percentage of midwives being reviewed is so small.

> *"They see it as a stick that's going to beat them over the head rather than as something they can use to help them walk down the pathway of reflective practice. People used to think it was like a secret society. That you had to be a home birth midwife to do it , that they didn't know anything about it and that it was a big yuck thing that no one wanted to do. I don't know if that has changed very much despite presenting it to the AGM last year and trying to get new people on the committee."*

Although the review is intended to be a tool for reflective practice, for some the review is seen more as a check on their practice, more as a quality assurance tool. Although the review has no statutory power it was seen by these two midwives as a controlling mechanism. Both were quite apprehensive about exposing their practice. It was still seen as having a "home birth " philosophical bent and they were both anticipating some degree of disapproval from the committee.

The decision to be reviewed for midwives within the Wellington area is one that a minority of midwives are choosing. The Wellington region is unique in New Zealand in that is has a large maternity provider organisation (MPO). It contracts directly to the RHA for the maternity funding for these providers (doctors and midwives). This organisation, called Matpro, subcontracts to these maternity providers and funds them. Matpro has its own internal quality assurance mechanisms built into its contracts. The

maternity providers must participate in 8 hours of peer review a year which consist mainly of interprofessional case presentations. For many midwives working under the Matpro umbrella the need for further assessment of practice seems superfluous. I also suspect that the NZCOM review process carries for them also an assumed purist or 'home birth' bent. Only 5 Matpro midwives have had their practice reviewed by the College of Midwives.

The cost of this review is also given as a reason for not being reviewed. In the Wellington area review will cost $250 with the additional cost of distribution and analysis of consumer feedback forms. Depending on the numbers of consumer feedback forms analysed this can bring the cost up to $300- $400. Negotiating with Matpro about making use of the MSRP are ongoing.

The reviewers

Consumers are an integral part of the review process. They are represented in equal numbers with midwives on the panels. In Wellington this means that the review panel has two consumer representatives and two midwives. Consumers are selected as representatives of consumer organisations. They are nominated by these organisations. Some examples in Wellington of these organisations are: Parent Centre, La Leche League, Birthwise, and the Home Birth Association. Chris was one of the consumers on Pat's review panel. She had been nominated by Parent Centre.

> *"I had my first baby in hospital with the hospital midwife and then had an independent midwife for my second baby. The difference was unbelievable. It was so great and I felt so safe and in control. When I heard that they*

wanted volunteers to go on the review panel I jumped at the opportunity. I saw it as being a way of helping other women have the type of experience I had. I thought it would be a good experience for me too."

Midwives on the panels are nominated by the local College of Midwives. For Pauline, one of the midwife reviewers it was her first experience.

"I have just set out in independent practice myself and feel that quality assurance is an essential part of that, and so immediately have started with the goal of being reviewed myself so got into the review process that way and then attended College meetings, heard that they needed someone for a panel on this side of town so I volunteered. Mainly because I want to do something for the work of the College but I don't want to be on committees".

For the panellists too then the review is seen as a way of improving the quality of midwifery care. During the interviews with the two panellists little mention was made of the support and growth aspects of the process or of the panel's ability to assist the midwife to be reflective. In practice though the process as it happened was quite supportive and much less threatening than the midwives had anticipated.

Currently there is no difficulty getting consumers and midwives to participate on these panels. In fact for the first few years there was a waiting list. It is anticipated that this may not always be the case. Certainly if the majority of Wellington midwives were to have their practice reviewed the availability of enough consumers may become a problem.

Preparing for the review

Many hours go into preparing for the review both by the midwives and the review panels. Both reviewers and reviewed midwives have received copies of the review tool and guidelines about the process. The review tool has 7 sections:

- A personal statement which includes a description of her practice and her personal beliefs about midwifery (See Table 4:1).
- Total numbers of women cared for including place of birth.
- A statistics sheet giving the details of every birth. There are 66 categories in all which include aspects of antenatal care, birth and postnatal outcomes.
- Goals from the previous and for the following years.
- A list of information resources and equipment carried.
- A presentation of special cases encountered during the year. These include those which were especially challenging or stimulating.
- The 10 Standards of Midwifery Practice are then covered, with the midwife answering detailed questions about each.
- Consumer surveys.

A compete copy of this review tool and guidelines for the midwife and the reviewers are attached in Appendix 3. The midwife receives both the review tool and its accompanying guidelines when she decides to be reviewed. Her review period generally covers one calendar year.

Table 4:1 Example of possible personal report (From training document 'Maddy Midwife', Appendix 4)

"This is my first review of practice. While I have only been practising as an independent midwife for 2 years I have been a registered midwife for 4 years. Prior to making the decision to go into business for myself I worked in all areas of midwifery at Wellington Hospital including 6 months on the High Risk Team. I also worked for 1 year in the Neonatal Unit. I am a member of the NZCOM and regularly attend meetings (babies willing).

When I started working independently I did not establish any definite goals or objectives. However I wanted to get away from the hospital model (in my eyes) of too much intervention in childbirth. I feel that since becoming an independent practitioner I have tried to achieve this aim.. I am also aware that my philosophy of childbirth and my needs as a midwife are still evolving. I hope that more experience of woman-centred birth will clarify my goals and philosophies.

I am currently working in a practice with three other midwives. I am happy with this arrangement and I enjoy working with local GPs in a shared care situation. I have cared for some clients in a midwifery only capacity and will attend home births as needed (3 during the review period). I do not carry out any 6 week checks as I believe that a woman's GP should do it (to ensure continuity of family care). I do not run antenatal classes for my clients as there are classes available elsewhere that cover this aspect of birth preparation well. I do not use a computer-based system but I am looking into it.

My plans (and therefor my objectives) for the next year are a little unclear at present. I will need to re-evaluate my working arrangements in the near future as I am (at the time of writing) 21 weeks pregnant. My own pregnancy has given me a new and special insight into the needs of my clients especially as I experienced severe morning sickness for the first 15 weeks. I was unable to care for some of my clients during this time and I felt quite guilty at having to get one of my associates to cover for me.

I have experienced many highlights and some personal challenges. These events have helped me to see my deficiencies and thus, exploit my strengths"

The midwives.

Cathy found the preparation for the review demanding and lengthy.

> *"I can't tell you how long it took because it took awful long time in 2 hour stints and then I'd give up and go and do some work and then come back and try again. But probably 24hrs in all I would think. It took a long time to do the stats sheet because I hadn't had it in advance and it was an awful lot to answer about every person . And then it took a long time to work through the standards and how to phrase things because you get out of the habit of academic work. I haven't done anything since bursary that was such a strain as that."*

Pat commented that it had probably taken her a good week full time. She had suffered a bad case of the flu and had her review postponed several times.

The Wellington coordinator does offer several sessions for midwives being reviewed to explain the review process and the tool. It is for the midwife a time consuming process in which there is the potential for much reflection about her personal philosophy, her practice management, her outcomes and how her practice is matching up with the Standards for Practice. By the time the midwife has worked through the tool during the preparation time, much of her own personal reflection has often been done. She has also formulated some objectives for the coming year. During the review the panel will add their own reflections and may also add to or amend some of the objectives.

The reviewers

Reviewers also take considerable time in preparation. They start by having two training sessions in which they are introduced to the review tool, develop interview techniques and explore the partnership model of midwifery in depth. They also meet the other members of their panel for the first time. There are further training sessions through the year in which such issues as conflict resolution and effective expression are provided by a trained facilitator. At this stage they receive a training document which includes guidelines to the review, a completed mock up review with sample questions, a review reporting tool which works through the issues corresponding to the reviewed midwife's tool, and a reporting sheet (Appendices 4,5&6). They receive the midwife's completed tool about two weeks before the review which gives them time to read and prepare some questions.

Pauline was one of the midwives on Cathy's panel. It was her first time as a reviewer.

> *"I was quite frightened about it because I felt quite responsible towards Cathy. I must have spent a good 6 hours preparing, reading, rereading and going back to the review tool. I only had the bare guidelines so had to shape it for myself to have some idea what we could do for Cathy. I felt very responsible and felt that I had to know the material very well".*

Chris was one of the consumer members on Pat's panel. She has been a reviewer for the last two years and felt much more comfortable with the process.

> *"I guess it takes me a couple of hours. I tend to have a quick read through it to get the gist of it and then go back over it more thoroughly a couple of days later."*

A crucial part of the review process is the evaluation of consumer feedback. During the midwife's working year she gives evaluation forms to women she has cared for.

Ideally they are posted to her at around three months after the birth. The women fill them in anonymously and send them to a paid College worker who collates them and notes the comments made. One copy of the collated forms is sent to the midwife along with all the completed feedback forms. The other copy is sent to one of the consumer embers of the panel for discussion at the review. There are two different forms which can be used - a standard one and one for mothers with English as second language (ESL) (Appendix 2). Since the fieldwork for this study was completed it has been decided at the 1998 annual review meeting that the consumer feed back forms will be further developed. It is intended that the new form will resemble the ESL form in that it will have a limited number of open ended questions to allow the woman's voice with her own concerns to be heard. They will not now be collated but be viewed in their entirety.

"Fronting up"

In this section I describe the review of Cathy so as to facilitate the readers understanding of the flow and ambience of the process.

It's 7 o'clock on a rather blustery Wellington night. The upstairs room at the local community centre has been booked for the review. The panel of four gathers, two midwives and two consumer representatives. Breast fed babies have been settled for the night, they hope. The midwives switch their pagers off and hope that their covering midwives don't get called. One of the midwives has been up all the previous night at a birth and hasn't caught up on all her sleep yet . The room looks rather

sparse so they rearrange chairs to make the place seem welcoming. Tea is poured, fresh hot muffins are consumed as they settle down to work out how the review will go. They have an hour to get organised. They work through the completed tool, add impressions and bring up questions and issues that have arisen for them. For one of the consumer reviewers it is her first time so they agree that it would be good for her to be the minute taker. She can do shorthand too so that will come in handy. Chris, the other consumer will chair the night. She will keep the process flowing and to time. It will be her job to set the scene, explain the process to Cathy, do the introductions and the conclusions and pass on the summary to the coordinator for typing.

The panel have all received their review reporting tool two weeks ago. It would be impossible to cover everything during the interview so the panel focuses on the issues which either they or Cathy have raised in their preparation. They steadily work through it deciding what questions will be asked and who will ask them. On the way through they highlight areas which might be appropriate for Cathy to work on as objectives for her coming year.

Cathy has sent feedback forms to all her clients but has had a low response rate. She has noted that she was unaware of the simplified form and that most of her clients are not Pakeha which may account for this. Her consumer comment however *"is all highly positive, all excellent feedback*". As she shares care with doctors there is quite a lot of comment about them. Negative comments relate entirely to the physical surroundings of the hospital or to the actual labour. *"I would have liked the labour to have slowed down".* Pauline has worked alongside Cathy in the hospital and comments on how positively she has viewed Cathy's care and the relationships she has

developed with the women she cares for. She is concerned that it might influence her review. The rest of the committee has no problem with this.

The panel goes on to discuss her personal report. Tricia thinks that Cathy seems a bit defensive about being in a shared care practice so they decide to ask her how she feels about this. They discuss their own experience of shared care and how they have developed. They note that Cathy has stated she intends to continue to practice like this until she retires. They decide to explore this and to check how she deals with women who want midwifery care only. Some of the questions they will pose cross over the different standards, particularly those concerned with her personal report and the statistics sheet. The panel are comfortable with dealing with this. They note where positive feedback should be given to her and decide where they would like her to expand on some of her comments. For example, they would like to know how she deals with birth plans where transfer to another hospital is a possibility, how she gets adequate time off and how the group paging system works.

Her two special cases seem to give a good picture of her practice and some of the problems she faces. They would like to know if she has some thoughts about how she might have handled her difficult situation differently.

Table 4:2 Example of a special case (From training document 'Maddy Midwife', Appendix 4)

I looked after a 33 yr. old woman with normal pregnancy. She had 1 previous child (which was a planned natural hospital birth) that resulted in multiple intervention due to being overdue, resulted in induction, emergency section, flat baby and feeding difficulties which ended in bottle feeding at 6 weeks *Her first child is now four. She delayed her next pregnancy as terrified at the thought of repeating the scenario. She had worked through her previous birth experience (supposedly), very keen to be in control this time around. Wished to have a planned home birth with the midwife (myself).* *Went into spontaneous labour at 41 weeks. Two hour birth, PPH 700 mls+ Baby not given Vit K although I wished (due to fast birth) but the woman refused to give consent. Woman's recordings not satis BP 70/40, pulse 112 - required transfer to hospital. Woman refused. Husband supported woman's wishes. "Why can't you do something here - give her glucose or something!* *My 2nd midwife not present due to fast delivery and traffic delay due to accident so I had no support. Had to facilitate emergency transfer to hospital against the woman's wishes. Recovered well from PPH. Home in 24 hrs. Baby fed well.* *The woman refused to see me again upon transfer to hospital. Laid a complaint with NZCOM complaints process which is still being processed. The woman has refused third party mediation* *Issues for myself: Safety for the woman, midwives need for professional safety and accountability, ethical issue of taking over woman's sense of control, ongoing sense of anxiety about complaints going ahead, lack of resolution, willing for mediation*

The panel notices that she seems to be doing a lot of documentation. They might be able to help her simplify it a bit. What is she doing about the documentation of telephone conversations and does she give copies of the notes to the women?

Throughout the process Pauline and Tricia, the two midwives, share some reflections about their own practice in comparison to Cathy's. The thought does cross my mind that the review process does have the potential to be too restrictive if reviewing midwives were not able to see the broader picture of practice models. It is good that there are two midwives there and that they have different ways of practising. At this stage Cathy arrives 15 minutes early so I find her a place to wait and offer her a cup of tea while the panel completes its preparation.

The panel then review her statistics sheet for any areas not already covered. They note lots of areas for positive feedback including the low rates of forceps, postpartum haemorrhages and episiotomies. They seem to agree that she can take some personal responsibility for this. The sizes of the babies are normal, she has a low premature delivery rate and her breast feeding rate is "*wonderful*". They do note that she has delivered only 16 of her babies, the rest being delivered by the GPs. They look at her own objectives for the year, take another look at the questions they will ask and in what order. *"That should keep us busy for an hour anyway"*. When Cathy comes in they decide to be less formal and be up and about, making more tea.

The review.

Cathy is welcomed, introductions are made and they settle down to begin the review. Chris explains how the process will work and encourages Cathy to relax

> *"We're not here to judge you. We hope to be totally non-threatening and supportive in our questioning, so please be honest. Everything here is confidential. Hopefully we will only take an hour so we hope to be finished by 10 past 9"*

Chris asks how Cathy has found the process of preparation and they discuss what hard work it is.

The process follows quite closely the plan of action prepared by the panel. The panel obviously enjoy sharing the story of Cathy's practice. The atmosphere does indeed seem relaxed and non-threatening and they manage to achieve a balance between positive comment and questions for clarification and challenge. They make it clear they are not disapproving of shared care but do make a suggestion for her not to dismiss entirely the possibility of increasing the extent of autonomy within her practice or to undervalue her own knowledge. Cathy responds, *"I think I always have."*

The concerns of the midwife panel members seemed to reflect the issues they face in their own practice. The review often goes straight to the heart of the matters that they wish to raise. The midwives share some of their own experiences with Cathy, seeming to provide an empathetic, mirrored experience for her to reflect in. She obviously values it. She hears, possibly for the first time ever, about how well she is doing. They

share laughter about some of the problems they have and share ideas for possible solutions, acknowledging difficult issues such as advocacy and communication with doctors. The mix and skill of the panel members seem to be able to provide a review which is clearly structured but which leaves room for empathetic and honest sharing. It seems like a 'bullshit-free' zone.

Each section of the review is covered, all the questions prepared are asked. They did not however develop any areas for which they were not prepared. I noticed, for example that the panel did not respond to Cathy's comment that many of the women she cared for had abusive husbands. Her clientele are clearly not white middle class and I wondered how well the panel was able to assist her in this very difficult area. One of the areas in which the panel did express some concern however was that Cathy did not carry Syntocinon and suggested that although she did not do home births it would be advisable for her to carry this for emergencies if a baby was delivered at home unexpectedly. This issue developed in several places during the review until it was acceptably resolved as one of Cathy's objectives for the coming year.

The meeting concluded with the panel asking Cathy how she had found it. *"Tonight hasn't been very frightening at all and I think you have offered some useful suggestions"*. She did add that she didn't see the value of annual review as *"when one has reached my age one isn't going to change ones practice very much"*. At this stage Tricia added her experience of being a midwife in later life.

> *"A lot of my confidence in moving my practice along came from reviewing my practice and from getting the feedback from other people that I was doing all right. So don't think it's ever too late."*

Thanks and best wishes were exchanged and Cathy left to go home. While Chris checked out the window to make sure she got safety to her car, the kettle was put on for yet another cup of tea.

The report

The panel then settled down to prepare Cathy's report. Having the whole review in shorthand was overwhelming for a while and expectations of how the report would be finalised were a little different but they soon got the hang of it and work proceeded smoothly. Energy levels were running a little low to start with. They had already put in a lot of concentrated effort. The report format was followed (Appendix 5). A new reporting form had been given to the chairperson that day so there was some discussion about how it should be used Then work proceeded. Again they followed the review tool, summarising the discussion and adding the goals and recommendations that had been discussed. Although several more questions developed during this time, the panel members were aware that nothing should be in the final report that had not been covered during the review. For an example of a completed report see Appendix 6. At 10.45pm it was all complete. Chris gathered up all the copies of Cathy's review from the panel members together with the completed report. She will drop it off in Rae's letter box on the way home. It is the coordinator's job to get the report typed and sent out to the midwife sometime in the following couple of weeks. One copy of Cathy's review tool, the consumer feedback

and the completed report will be stored in Rae's bulging filing cabinet. The remainder of the copies will be destroyed.

Feedback

Within a couple of weeks of the review Cathy receives a report together with a certificate confirming she has been reviewed and a letter which she can give to the local CHE Obstetric Standards Review Committee should she need it when her access agreement is to be renewed. She also receives a feedback form in which she can give the coordinator comments about her experience of the review with any recommendations about how she thinks it could be done better. I visited Cathy at her home a week following her review to talk with her about how she had found it. She thought it was non threatening and encouraging and

> *"...quite useful really. It was better than expected as I thought it would be quite critical of my conventional approach to midwifery".*

When I asked her if it was challenging enough she stated that it was challenging enough just going there.

> *"I think it was useful because it made me look at my practice and why I did things instead of blindly going on doing the same things and presuming that they were all right and so it did make me think about why I do things and why I work with GPs. But I'm not sure whether financially it was worth it annually"*

It cost her around $500. Cathy stated that it wouldn't make any difference to her practice but that she would carry syntocinon now. I asked how she felt about consumers being involved.

"I hadn't really thought. I just accepted the panel and thought that was how it was done. The consumer lady who led the panel seemed to understand it very well"

She would definitely recommend it to other midwives.

Pauline, one of the midwife reviewers was also pleased with the review. I interviewed her also a week later.

"I was very pleased because I felt that the review did get to the heart of Cathy's practice and the issues that were pertinent to her so I felt that the process worked and was worthwhile."

Cathy confirmed this when I spoke to her. She thought the panel had obviously prepared well and had managed to get an accurate picture of the nature of her practice. The panel also get a chance to feedback at regular debriefing meetings where concerns can be expressed and ideas for changes or additions to the review can be discussed.

Comment

The question might then be asked what difference does it make to the midwife and her practice. How does it enhance or change it? Neither Cathy nor Pat felt it had made any significant change. What then is the point of it? It became clearer when talking with College of Midwives representatives that change might happen more gradually over a few years as midwives, who have often recently emerged from the more sheltered environment of hospital employment begin to come grips with the nature of autonomous practice. They commented that it was common to see a midwife returning to be reviewed in subsequent years having expanded the nature of her practice considerably. Most commonly this was in such areas of midwifery only

practice, or a reduction in intervention rates. It was often expressed in terms of more confidence and a willingness to act upon her own decisions. Certainly it was felt that the support, affirmation and encouragement received at the time of the review might act as a springboard for growth and development and the review is an ongoing process not just a once a year job.

Rae described what has been happening in Wellington.

> *"Last year we were so worried about how the midwives would take being reviewed by the panel. They were incredibly lovely to people. They were warm and empathetic and were hesitant about asking questions that might be seen as being nasty or critical. Maybe those people who had their first reviews did wonder whether is was useful or not. There had been so much fear about it that we were trying to allay that by our approach. But I think the pendulum did swing in the other direction a bit much. So this year I've said to people that you still need to do that but you need to remember that it needs to be constructive. So after that last debriefing we had I will send out and include with the training document whether it is this person's first review. If so you need to be gentle but real with them. When it is their second review you can get stuck in a bit more and challenge them a bit more or maybe you can focus of a couple of standards a bit more."*

It is worth noting that since this study has been completed the plan for the reviews have been changed. The panel will no longer meet separately from the midwife after the review, but develop a Personal Development Plan with the midwife and she takes it with her when she goes. The MSRP committee will keep no record of the review but will simply note the name of the midwife, her reviewers and the date of the review. The rationale for this is twofold. As the review is for the midwife and the committee are not expected to take any independent action, they need not keep any documents.

There have also been several attempts by CHEs and lawyers acting on behalf of families taking action against midwives to obtain copies of the review. In order to prevent this the committees will no longer hold any copes of the midwife's documentation or development plan. It will be up to the midwife to bring her previous year's development plan to the subsequent review.

Behind the process

Local co-ordination

The review process in the Wellington area is run by a group who form a subcommittee of the local College of Midwives. The coordinator is Rae who is paid to keep the process running. Rae is a consumer who has been actively involved in La Leche League and the Home Birth Association. She has two pre-school children and is about to have her third. I interviewed Rae at her home in the company of four pre-schoolers - who came with singing circles and piano playing - and pauses to console a tearful two year old and to open the jar of pickled onions. She is a busy mother! She is absolutely committed to the review process and has spent many hours developing the paper work involved which includes such things as the guidelines, the teaching documents and the reporting tool (Appendices 4 &5). She has been involved in the process since its early days in Wellington, first as a consumer representative both on the committee and as a reviewer and secondly as the co-ordinator when it became apparent that someone with energy, commitment and some spare time would be needed to see it run efficiently.

The co-ordination of the review process involves:

- making direct contact with the midwives in the area both by post and on the phone to inform them of the review process and to offer times for review
- finding midwives and consumers to be on the panels
- providing training sessions for both reviewers and reviewees
- preparing and modifying the review tools and guidelines
- managing the budget
- organising venues, photocopying and posting midwives completed tools to the panels, typing and posting reports, storage of completed reviews, consumer feedback forms collated
- meeting with the midwives review committee to make decisions on costing, amendments to the tool, training and planning
- communication with local midwives- at meetings and in the local newsletter
- annual reporting to the local COM meetings

Because only around 25% of Wellington midwives are currently having their practice reviewed by the College, Rae spends a lot of her time and energy encouraging midwives to get involved in the process. This involves extra mail outs and a lot of time on follow-up phone calls. She is also currently negotiating with Matpro to encourage those midwives to look at having their practice reviewed. Last minute date changing, cancelling and of course births, all add to making the smooth running of the process somewhat difficult. Rae currently receives $100 per review, which actually compensates her poorly for the hours she puts in. If a higher proportion of midwives

were to be reviewed, the economy of scale would make it easier to run and ensure a more realistic income for her.

Rae sees the review as a tool for quality assurance and as a way of potentially gathering national statistics. It can be a way of monitoring what midwives are doing and to see whether independent midwifery makes any difference in terms of outcomes for women. At the present time in New Zealand there is no national perinatal database, so information about what is happening here is very poor. The review process does have the potential for gathering information about midwifery practice, especially when the statistics can be nationally collated. This will of course rely on midwives being under some compulsion to present their data annually. She also sees it as a reflective tool for the midwives.

> *"At the end of the day the process is for them, not the panel and I think people struggle to understand that. They see the review as some sort of exam and they feel threatened by the panel."*

She sees peer review, where practitioners look at difficult cases, as fulfilling quite a different purpose.

> *"Peer review is completely different from a midwifery based reflection on your year's practice rooted in the midwifery model. This model means partnership with women, continuity of care, informed choice and women-centred care. It is a process for midwives, by midwives and consumers. If we don't get this on board then it is a loss for the midwifery profession and for those women who are receiving midwifery care."*

She thinks the process is slow in being taken up by Wellington midwives because it is still seen as being tainted by a purist home birth philosophy and is thus seen as being

irrelevant to those midwives sharing care with doctors. It is also perceived as being very expensive, time consuming and unnecessary for contracts. Midwives contracted to Matpro are obliged to be involved in a specific number of hours of peer review which includes the doctors. They often see this as being sufficient to fulfil their needs for practice development. Midwives in Matpro are also less likely to be involved in the College of Midwives.

Rae sees the process as potentially developing some minimum standards which she doesn't see as being particularly clearly defined yet. It also has the possibility of becoming an accreditation tool. If it were to do so she sees it as needing to work at quite a different level.

> *"I think that the issue there is setting up a body who could administer it sufficiently to do that properly and I don't think that voluntary consumer panels and co-ordinators like myself could actually do that justice."*

A pass/fail point also caused her some concern.

> *"How honest are you going to be if you are going to be judged on a minimum standard? It you know you have to come up to a certain point to carry on practising then you're going to make yourself come up to that point no matter what."*

She would also like more support and involvement at a national level as she has felt a bit isolated reworking the tool and accompanying documents in isolation from the rest of the country. The recently completed national document arrived after she had done most of the work herself. She would like to have one person nationally responsible for assisting with and standardising the process.

National co-ordination

The national office for the New Zealand College of Midwives is based in Christchurch. While there I interviewed Karen Guilliland and Bronwen Pelvin. Karen is the National Director and Bronwen the Midwifery Advisory Officer. Both have been very involved in the review process from its inception. The College has run national workshops for the review process for four of the last five years. These workshops have been attended by the members of the national committee and the regional MRSC co-ordinators It has been a valuable undertaking in that it has clarified the aims and objectives of the process, developed its structure and modified the paper work involved. It has also been helpful for the co-ordinators in smaller areas where review was in its infancy and where small numbers meant the resources were limited. It has also allowed for some national standardisation. The preparation of the information kit in 1997 has provided a comprehensive guidelines for areas developing their review process or for new co-ordinators and committee members.

Up till now the College has not has a staff member directly responsible for overseeing the review process. There is limited national data kept on numbers of reviews or their outcomes. There has also been limited data kept regarding the outcomes of midwifery care. This is seen as a major drawback. Midwives need this information both for their own development as a profession and to illustrate to the public and health funders that midwifery care is a safe option. At this stage then we have inadequate national data on which to base any assumptions about the maternity care midwives, or indeed any health professionals, provide. This is a problem well identified by the national office and

steps are underway to remedy it. Karen Guilliland is in the process of completing a Masters Thesis which will provide some information on midwifery practice, and a data gathering package. This may be used by midwives as part of their statistics gathering within the review process and may be able to be collated nationally. This seems to be an issue that is not isolated to New Zealand, however. The American College of Nurse-Midwives for example has developed its own clinical data set for the gathering of statistics for the purpose of both practice review and national data collation (Greener, 1991).

There are also steps underway by the health authorities in New Zealand to develop a national perinatal database which should also be able to provide useful data about the outcomes of maternity care. It would also be useful to have a national resource person for the review process to provide guidance and possibly some training for review panels. She could also be responsible for providing the national link-up and for monitoring the quality of the reviews. Plans are underway for another national meeting next year. No doubt some these issues will be raised then.

At the national level concerns were expressed about the nature of the review process in terms of what it is that is trying to achieve. Karen commented:

> *"In the first couple of years there was an evangelistic streak where some of the committees wanted to do away with Vit K and ultrasounds. The purest midwives saw other midwives as being tainted by medicine. Standards review was often seen as a way of having that presented. It was hugely rigorous with a large degree of judgement. But if you really do work using the partnership model then you are going to have a whole range of women choosing different things and a whole range of midwives working in different*

ways because that is the way of the world. So you need to start the process gently. A lot started very hard and put a whole lot of midwives off. This is an educative process and it has to start gently."

By the time of the second workshop in 1995 the panel were much more realistic. Bronwen commented:

"Certainly as time went on the committees were exposed to a wider variety of practice issues. The committee's approach has been to try and transform the process into an educative and supportive process rather than one which judges a midwife against an impossible to attain standard. That is a significant development. It has moved from something that was there to make sure the midwives were toeing the party line to something that sees midwives much more on a continuum from medical model to midwifery model and that midwives are somewhere on the continuum."

Karen commented on the value that the review process has had for the midwifery profession:

"I think what we have done from 1990 has been huge. It was done overnight with no measure of accountability in place. For me the MSRC was like a lifesaver. I thought it was an absolutely essential tool for assisting midwives' understanding of what autonomy is. I now think we have moved from being a supportive discussion to being a quality assurance programme. I think the aim for me is to put everybody through standards review by trained people who know how to conduct a quality assurance programme and that some type of annual practice review is compulsory."

I asked Karen how she thought compulsion for review would affect its supportive character.

"It doesn't take away from that process still being educative and reflective. The compulsion is that you do reflect, that you do take part in an on going

critique of your practice. One way of review might not suit everybody. You would just have to hope that if we can set up our process with properly trained people who understand the dynamics of what goes on that midwives would choose that way. I think they probably will, given that many do now."

What the national office would like to see is some sort of compulsory practice review and that the majority of midwives would choose to use the College review process.

Another aspect that seems to be assumed by many involved in the review process is that somehow if a midwife is being reviewed then her practice is acceptable. Some areas have attempted to publish the names of reviewed midwives. Karen comments:

"It was never a College idea to have a tick off process. It is not a stamp of approval. You cannot say that being reviewed gives you a guarantee. If you make it like that you are setting the MSRCs up for all sorts of legal issues. It doesn't establish competence. Simply to have done the review is enough. All you can say is that someone is trying, which is better than saying someone is not trying. All we are saying is that it is compulsory to be seen to be trying".

Indeed there have been legal issues raised in one area where a committee gave a very negative review to a midwife. This had the potential to make difficult her access to the local hospital facilities and thus her livelihood.

The Standards for Practice that the College has developed are standards of excellence, not minimum standards. To use these standards as an attempt to provide a pass/fail mark is seen as being doomed to failure. Bronwen comments:

"I think that the standards review process is a performance appraisal. Because midwifery is an autonomous profession you do your own appraisal by producing your statistics and going through the standards one by one and

reflecting on whether your practice has in fact met those standards. The standards that the College has are in fact standards of excellence. In real life no one is perfect. I hold the view that there would never be anything that I did that I couldn't improve on. I think that's true of everyone. I think that Standards Review the way that we have set it, as a performance appraisal and as an educative and supportive atmosphere and process that midwives can go through to improve their practice, is hugely complex. I think it is not a simple thing that we are asking midwives to do. I think we don't give credit to the midwives or to the review committees. It is actually a big ask because nobody else does it. I still think that the process is a very good one but it is difficult and I think that we will see some refinement of it over the next four to six years."

Wider health sphere

Midwifery practice in New Zealand exists within a health environment which has seen radical reform over the last 15 years. The most radical change has been the split between the funders and the providers of health care. Even though the country is small, it has had four different funding agencies called Regional Health Authorities or RHAs. The providers of health care had to contract with their local RHA. The contracts are based on service provision and follow a competitive model. Local hospitals are now known as Crown Health Enterprises or CHEs. Providers of maternity services which includes the CHEs were all required to contract with their regional RHAs for funding. Since the fieldwork for this study was completed, the structure has changed yet again. The RHAs have been disbanded and there is now one national funding body called the Health Funding Authority (HFA). The competitive

nature of health care is to be reduced but there has been no sign of this happening as yet.

Within the Wellington area there are two CHEs providing maternity care as well as the obstetricians, general practitioners and midwives working in the community. Theoretically they are seen as competitors. As stated earlier, many of these maternity providers have come together to form a maternity provider organisation called Matpro. Matpro contracted with the central RHA for the funding of its members. Other examples of collective contracting in Wellington are found within the Union Health Services, who provide primary health care for low income families, and the Domino Midwives, a group of seven independently practising midwives. Other health practitioners who do not have any sort of collective contract are funded by a national agency known as Health Benefits Limited (HBL). The amount of funding through HBL is determined by a joint committee with representatives of the RHAs and meets with doctors and midwives to decide the amount and distribution of the funding. It has been an exceptionally fraught process still not resolved after years of negotiation.

Those practitioners with group contracts with the RHA, which includes the CHEs, have all had requirements for quality assurance mentioned in their contracts. Those practitioners accessing funding through HBL do not. Neither are there currently any criteria for ongoing education or practice review built into the annual practising certificates for these practitioners. It is anticipated that this will change with amendments to their respective Acts of Parliament.

To complicate matters further, doctors and midwives who provide maternity services, but who are not employed by the CHEs, must negotiate access agreements with the CHEs to use their facilities. The majority of Wellington women have maternity providers who are not CHE employees. The RHA has stated in its contracts with the CHEs that the CHE must be responsible for ensuring that the practitioners who access its facilities must practice at an acceptable level. What exactly this level is is not specified in the contracts.

For the CHEs this has caused some difficulty. Because the model of funding is a competitive one, the CHE is theoretically competing with the practitioners it is granting access agreements to. The Commerce Commission is quick to act on any case of anti-competitive practice, so the CHEs must be extremely careful about denying access to any practitioner who requests it and is often in a bind between their legal obligation to allow appropriately qualified practitioners unrestricted access to a public facility, and ensuring that care provided in their facility is of an acceptable standard. To complicate things even further, CHEs have been subject to multiple structural reform over the last 10 years, especially within management. Knowing the lines of responsibility and decision making is often difficult, as things are put on hold until yet another review is complete. They are then generally unsure as to how far they can go in insisting that a midwife with an access agreement is involved in peer review or other quality assurance mechanisms.

Of the two CHEs in the Wellington area one does require evidence of audit and peer review activities, the other does not. The impression is that it may require a legal challenge by a midwife or doctor refused access because this evidence was not

produced before the matter is clarified. The CHEs are also very concerned about the public perception that they must take some responsibility for the quality of these practitioners. In a recent case involving the death of a baby while under the care of independent practitioners, one of the Wellington CHEs was criticised by the local media and was subjected to some thorough questioning by the police and the coroner about their involvement, even though no CHE employee was involved. One can understand their dilemma.

Another aspect of the midwives review process that became more and more apparent to me through all my interviews and this was true also when talking with local health authorities that there is some assumption that if a midwife is being reviewed by the College them somehow this provides some sort of guarantee that her practice is of an acceptable standard. This may in fact not be the case. One can presume that if the process is voluntary then the midwife must be wanting to improve her practice. If standards review were to become compulsory however, this will not necessarily be true and midwives may complete a review without any attempt at improving their practice. Organisations who have developed standards for accreditation, such as the New Zealand Council on Health Care Standards, develop them as minimum standards, with a clear pass/fail mark. Funders and consumers of their services are provided with some indication of quality. The midwives review process comes with no guarantee for either funders or consumers.

It will be the College's decision about whether or not they wish to do so. It is ironic that health authorities may have some justification in seeing the current NZCOM

review process as an indication of professional competence while it remains voluntary yet if they are to make it compulsory it may not.

However it does look as though compulsory reaccreditation will become a reality. The NZ Council on Health Care Standards has developed Accreditation Standards for Health and Disability Services. Standard 6 looks at Human Resource Management and covers the credentialling of independent health practitioners. It includes: *"participation in quality activities within the organisation, participation in professional activities which ensure the maintenance of competence, and the provision for recredentialling"* (NZ Council on Healthcare Standards 1997). The Nursing Council of New Zealand in reflecting on the 1995 change to the Medical Practitioners Act is presuming that when the Nurses act is reviewed, which should be soon, it will also have the function of developing competence-based Annual Practising Certificates. Its strategic plan, released in April 1997, establishes this as one of its strategic issues. Their objectives are:

> *"to establish criteria for competence-based annual practising certificate renewal adopted by the nursing and midwifery professions, to achieve legislative change to enable conditions to be applied on practice and to develop and manage processes to be implemented by the Council following legislative change"* (Nursing Council of New Zealand, 1997).

The NZCOM is working towards the possibility that the legislative change will include a separate Midwifery Council and has presented submissions to Government regarding this. However competence-based Annual Practising Certificates would be included in a new Midwifery Council.

Other models of review

The model of review developed by the New Zealand College of Midwives is unique. I have not been able to find a system of review anywhere that has involved consumers within the review process itself although it is now common practice within most professional review mechanisms to include consumer feedback. The NZCOM has built into its philosophy the concept of partnership with women, and they have included consumers at all levels, including that of its professional organisation both locally and nationally. It has also been difficult to find any other professional group that evaluates actual performance of practitioners, gathering details of their practice together on an annual basis to reflect, compare with standards and plan developments or improvements for the coming year. It is thus difficult to compare the process here with how it might be working elsewhere. However it is useful to look at how midwives elsewhere and how other health professionals monitor their practice.

When looking at other models of midwifery review it is important to look at those midwives who practice autonomously, specifically those who provide continuity of care throughout the childbearing experience. Sadly there are few places in the world where this happens to any large extent. Performance appraisal of midwives employed on a shift basis within hospitals bears little relevance to the work of the independent midwife.

North American models

American nurse-midwives in the State of Pennsylvania have developed a model of peer review most closely related to the New Zealand process. Thompson (1986) in her description of this process defined peer review as

> *"...a mutually supportive process whereby an individual or group's current practice is evaluated according to predetermined criteria (standards) by a group of one's professional peers. The successful completion of peer review is intended to assure the public and other professionals of the competence of the practitioner and the quality of his/her practice"* (p. 290).

The review involves a site visit by two peers, one of whom must have experience of a similar practice, for example home birth. During the site visit, practice protocols are assessed, charts are audited, statistics from the past year are viewed, Certified Nurse Midwifery (CNM) staff are all interviewed, other clinicians familiar with the CNM's practice are interviewed and a verbal report is given on site. This is followed by a written report. All record of the visit by the reviewers is destroyed and complete confidentiality is maintained. There appears however to be no consumer input. Interestingly many of the concerns expressed about their process we also share. These include issues of confidentiality, time commitment, cost, trusting peers to evaluate properly, and what to do when standards are clearly not achieved. The legal liability for peer reviewers to disclose is also an issue that midwives in New Zealand needed to clarify.

The American Midwives Association at a national level has developed a system called Continuing Competency Assessment. This consists of a series of 5 yearly cycles of

continuing education and examination. This process has no practice assessment or consumer involvement and involves the accumulation of certificates of continuing education (The American College of Nurse-Midwives, 1997).

The United Kingdom

The United Kingdom has a process of monitoring practice which they call supervision Since 1902 there has been statutory obligation for midwives to be supervised. Initially this was to designed to control midwives but has developed over the years to include a supportive role. This has been achieved with various degrees of success. With the medicalisation and institutionalisation of childbirth, supervision became a role that the midwife manager undertook (Kirkham,1996). This role then seems to combine both discipline and support, supervision and management. Independent midwives practising in the UK generally have poor regard for this type of supervision. Jill Demilew in her research into independent midwifery found that supervision as it existed was experienced negatively by the midwives.

> *"The midwives clearly and powerfully articulated supervision as being usually practised in a controlling, obstructive way. The irony is that it often had the effect of obstructing their clients from accessing the best quality care. This is the very opposite intention of supervision"* (Demilew in Kirkham 1996, p.195).

It is interesting to note that in New Zealand we firmly separated out the disciplinary from the supportive role very early on in the development of the review process for this very reason. One third of the midwives Demilew interviewed, who were all

experienced and politically aware, thought that supervision in its current format was inappropriate (Ibid. p.196).

It is interesting to note that some of the most experienced and politically aware midwives within the Wellington area are now having monthly supervision as well as their annual College review. Their supervision is however with a trained counsellor who specialises in supervision, not necessarily a midwife. The purpose of the supervisory sessions are to discuss the practice outside of other midwives' preconceptions and expectations. They also look at practice management and interpersonal issues.

Other independent health practitioners in New Zealand.

Within New Zealand the group of independent health practitioners with which to compare midwives is doctors. In 1995 the government passed the new Medical Practitioners Act which gives the Medical Council of New Zealand responsibility to monitor and ensure the competence of all registered doctors. The Royal New Zealand College of General Practitioners had begun a reaccreditation programme in 1994. It is based on

> " *the principles of self-directed learning and continuous improvement. The programme runs over a five year cycle during which the member must gain 250 credits. Members are required to produce an annual professional report and plan where they identify community, practice and personal needs and outline a plan for meeting those needs. Credits are gained for medical audit, research, educational activities, further study, teaching and any other activity that can be construed to improve care to patients. The professional report and plan covers an analysis of the GP's patient population, professional support , health and personal growth needs, learning needs, practice development and goals"* (Large,1997 p.50).

It is similar to the NZCOM's review process in that it stresses self assessment, but has the advantage of more flexibility as the doctor can choose which modules are most appropriate. It also differs from the MSRP in that credits are accumulated. There is however no requirement for direct face to face involvement with assessors, nor do consumers play an active role in assessing the practice other than by answering feedback questionnaires.

Physiotherapists practising independently in New Zealand have a process of review which is based on the New Zealand Council on Healthcare Standards (NZCHS) accreditation process. It is a practice accreditation not an individual review and looks at such issues as systems operations, physical environment, occupational safety standards and documentation. It includes the systems of quality improvements in place and a processes for peer review. It is based on the NZCHS's nine standards. A surveyor visits the practice and if accredited then it is valid for 3 years. As many physiotherapists do not rely on Government funding, such accreditation is not required in law. The NZ College of Physiotherapists also has a system of point accrual for individual members activities associated with ongoing education and development.

One thing that does become obvious from looking at effective maintenance of professional standards is that it is a very expensive business. The Canadian model for medical reaccreditation, for example costs $6,000 per practitioner (ibid.). In New Zealand it would cost a small service, such as a GP practice, around $6,000 for accreditation (O'Connor, 1993)

CHAPTER FIVE: ISSUE DEVELOPMENT

In describing the review process it has become apparent that there are certain concepts and issues which are of principal significance. It is also apparent that these are interdependent. Those of most relevance are: quality assurance, reflective practice, supervision, competence, and feminism..

It is not in the brief of this work to develop these in depth. I do however intend to present an overview of these issues and in particular to discuss how they relate to the midwives review process.

Quality Assurance

> *"In the early 1990s 'quality' - quality assurance, accreditation, total quality management, continuous quality improvement- was becoming prominent in discourse on health services in New Zealand and internationally"* (North, 1995, p.66).

In the 1991 health reforms, announced in the New Zealand Budget, 'quality' became institutionalised. The purchase of health services was to be set out in contracts, and quality parameters could be specified (ibid.). How quality is defined though, is very complex. Attree (1993) in her study analysing the concept of quality found that interpretations varied significantly according to the perspective of the observer and varied according to time, context and place. From the literature it emerged that the

word quality was used to mean : excellence, an ideal, meeting standards, meeting consumer need or being of value to the customer. She states:

> *"The concept 'quality care' is not used consistently, it is enigmatic and multi-dimensional. Requiring examination in context, and as it correlates with other concepts."* (Attree, p.367)

Quality is also a very value laden term. Clarification of what is valued is an important step to make before attempting to assess the quality of what is provided. It is not a simple process. Any professional organisation needs to have clear consensus about what is most valued before they develop assessment tools. In general, quality assurance has been presented as an institutional, system based process, professional assessment being only one small part. What is not explored in the literature is the question of which attributes/criteria of quality care should be measured and whose perspective should be adopted.

The quality of the midwife

The NZCOM Review Process can clearly fit into the broad category of QA and this was certainly the intention of the initial home birth reviews. It now involves comparison against standards of excellence, and relates closely to consumer need; consumer feedback forms being an integral part of the process. It has also been developed against a backdrop of a well developed value system elucidated in the NZCOM philosophy and Code of Ethics (New Zealand College of Midwives,1993). What it has not developed however is a pass/fail point. This is related to the fact that the standards which the college has set are standards of excellence and that the review

process has developed principally as a supportive and educative process not as a disciplinary and regulatory mechanism. It stands at the moment as a voluntary process thereby enabling the midwife to be more freely and honestly reflective of her practice. There are no negative repercussions of being reviewed.

This approach to quality assurance by the NZCOM reflects its philosophical base ideally. Essentially a feminist profession, midwifery's decision to construct a QA process which rejects the centrality of positivist forms of knowledge is an expression of women's ways of knowing. This is seen by observing

> *"...the dominance of the life-strategy of communion (Bakan,1996) which is more associated with women. It is characterised by openness, willingness to share and a readiness to accept new ideas. It can be argued that these are important precursors to reflective practice and indicate an orientation to non-positivist forms of knowledge. The life-strategy of agency, which is more associated with men, is characterised by a desire to control, a tendency to separate off the non-controllable features of life and to deny the life-strategy of communion. Again it can be argued that these characteristics predispose individuals to positivist forms of knowledge and are likely to inhibit reflexivity"* (Clarke, James, & Kelly, 1996, p. 179).

A mechanistic, reductionist approach to measuring the competency of the professional has been rejected in place of an emphasis on growth and development of the professional. The panel has a clear partnership with the midwife to assist in her professional development. The midwife for her part is responsible for representing her work honestly and accurately. A safe environment for her is imperative. This is where the review process is so unique. There is no compulsion to enter the process and no possibility of negative consequences. It is in the end the responsibility of the midwife

to maintain and develop her expertise. The following discussion on reflective practice will develop this aspect further.

The College accepts a professional must undergo some QA process and that not all midwives may wish to use the review process it has developed. As the process relies heavily on reflective practice it is imperative that it must remain voluntary, with no pass/fail point. This moves contrary to current thought about benchmarking and standard setting in which minimum standards must be achieved. It has been somewhat difficult for others to comprehend - that somehow QA might ensure that quality is being provided when in actual fact the process for independent health providers is one of professional development, focusing on the majority of providers whose level of care is already acceptable. What the review process has discovered is that in order to improve practice and enhance learning an environment must be provided which is both supportive and challenging, with no link whatsoever to disciplinary, regulatory processes. This issue will be developed further in the following section on competency assessment.

It is apparent that some QA mechanism will become compulsory for all health practitioners. The recent amendment to the Medical Practitioners Act requires that Annual Practising Certificates will not be issued if the Registrar believes that a doctor has failed to maintain a reasonable standard of professional competence, has not satisfactorily completed the requirements of any competence programme or has not met the recertification requirements (Large, 1997). Midwives will also have the same requirement applied when the Nurses and Midwives Act is amended. Indeed the New Zealand Nursing Council is being proactive about this and intends developing a system

of competency based practising certificates by the year 2000 even if the Nurses Act has not been amended.

One of the difficulties with a compulsory QA process is that in making it mandatory the potential for the process to be truly reflective, educative and supportive may be lost. The New Zealand Council on Healthcare Standards, a national accreditation body for healthcare providers, sees this as a difficulty. Its executive director stated that the council did not want to be a wielder of a big stick or to be cast in the role of inspector of services.

> *"The most important thing will be to have ongoing education on the value of accreditation. We do not want accreditation being perceived as an inspection. That is not an effective way to improve standards. Our role is as educator and coach, not inspector" (Connor,1993)*

This may be impossible to see for the rest home which has been denied accreditation, given that its funding is linked to accreditation.

How will the midwife view the Midwives Review Process if she must be found to be acceptable by it in order to continue to practice? How honest will be her presentation, how deep her reflection, how expansive and innovative her practice? On the other hand it is widely acknowledged that the notion of true accountability does require some degree of compulsion. The issue for the NZCOM then is how to develop and promote their Midwives Standards Review Process in order to meet present and future QA requirements without jeopardising its unique attributes as a reflective tool.. The NZCOM proposes the concept that because it doesn't have a pass/fail point, this doesn't make it any less a QA tool. In fact they would propose that the opposite is

true - that the nature of the process facilitates true reflection, real challenge and perceptible growth.

The quality of the system

Another difficulty with quality assurance mechanisms within the health structure is that in order to accurately view the quality of the service being provided, a larger view is required than that of the single practitioner. Using a system approach, one could view the outcome of care as being a result of many inputs and in order for QA to be valid a macro view is important. This macro view provides in particular a view of a combination of inputs used and their relationship with the quality of the resulting outcome. The micro view relates structure, process. and outcome to particular isolated inputs, such as a single health care worker. Alessi (1996) views the micro view as inferior to the macro view *"because it fails to capture the production function in its entirety and as such, does not address the issue of quality."* She sees real professional risks with quality assurance systems focused on the processes and characteristics of single inputs, such as those of a single health professional.

> *"Formal standards for quality assurance when based on a single input to service run a risk of freezing practice and discouraging practitioners from experimenting with innovative methods of health care delivery. An isolated focus on processes of service provision may become even less adaptable in terms of how they are provided, and even less responsive to community needs"* (Alessi, 1996, p.3)

Atree (1993) reinforces this view when she discussed QA in terms of evaluating outcomes of care which she sees as an international trend. She categorised outcomes

as occurring in six areas;: health/wellness level, functional ability, patient satisfaction, resource utilisation, undesirable events and undesirable processes. She suggests that all areas should be covered when evaluating quality. At this point in time the MSRP does not involve itself with evaluating outcomes of care such as cost effectiveness, or issues of error caused by system inadequacy or malfunction. For midwives this means that the inputs into and outcomes of their care and the consequent assessment of these involve many factors over which she may have little control, such as the nature of the population she cares for, the institution in which she works, or the support systems and services available. This a very real danger with the MSRP as it exists. The panel can view the midwife as being solely responsible for such things as her breast feeding or intervention rates. Certainly the MSRP could be further developed to assess and collate other factors in the midwives' working environment. It could present recommendations to relevant health agencies such as the local hospital or funding agency about factors which are causing a failure to provide adequate standards of care. This would include system error. This is a role which the MRP has not developed. As Atree (1993) stated:

> *"These issues require urgent attention if the various perspectives of quality: i.e. patient; professional; provider/producer; purchaser/payer and public/society, are to be represented in the evaluation of quality care."*(p 367)

The quality of the data

Given the need for QA to be undertaken at a broader level than that of the individual practitioner, it would seem appropriate that the NZCOM undertake to investigate

midwifery outcomes at a national level. At present midwifery data are not being collated at a regional or national level. New Zealand has no perinatal database. We don't know what midwives do! Analysis of midwifery outcomes is not available even in terms of physical outcomes. Internationally much work has been done on the development of perinatal databases for the purpose of measuring or assessing midwifery care (Fullerton & Wingard,1990, Weigers, Keirse, Berghs, & van der Zee, 1996, and Greener, 1991). At present the NZCOM is developing a data base for midwives in New Zealand. This would enable the data collected by each reviewed midwife to be collated nationally. We would then have some indication about what midwives are doing and about the outcomes of their care. The review process could then have the potential to extend the QA process from individual practitioner to the profession as a whole.

Another possibility of a midwifery data base is that given midwives are involved in all births in New Zealand, they could collect and collate data on all maternity care. The NZCOM could collate the data being prepared by reviewed midwives to make some comment about the outcomes of midwifery care and could also collate other information such as patient satisfaction or system failure. This could then enable the Midwives Review Process to be a supportive, educative tool, a way of maintaining an Annual Practising Certificate and a method of providing a comprehensive overview of the outcomes of care being provided by midwives within New Zealand's maternity system. It certainly has the potential to do so.

Reflective Practice

When professionals want to look at their practice it is useful to have a framework within which to do it. For midwives, the ideas around reflective practice provide such a framework. Donald Schon (1983) provided a useful theoretical analysis of the nature of professional practice and analyses the meaning and process of reflection.

> *"In the varied topography of professional practice there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solutions through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution"*(Schon,1987, p.3).

It is often the problems in the swamp which are of more concern. The MSRP helps midwives look both at the high, hard ground and into the swamp.

Professional practice.

According to Schon, professional practice has certain characteristics:

- The problems professionals face are messy and complex with no absolute right or wrong.
- The knowledge of the professional is broad, deep and multifaceted.
- The context in which the interaction is occurring is important and significant.
- Professional practice cannot be understood in terms of skills alone.
- Professional knowledge is difficult to articulate. (Schon, in Clarke et al, 1996, p.172)

An epistemology of technical rationalism looks at the high hard ground. Although it is critical for the professional it is inattentive to practical competence and professional artistry (Schon,1987. p.viii).

> *"In the terrain of professional practice, applied science and research-based technique occupy a critically important though limited territory, bounded on several sides by artistry. There is an art of problem framing, an art of implementation, and an art of improvisation - all necessary to mediate the use in practice of applied science and technique."* (Schon,1987, p.13.)

The premise of his work is that competent professionals have in their work a core of artistry. This artistry is an exercise of intelligence, a kind of knowing which differs from the standard models of professional practice. Although difficult to articulate it is not mysterious and can be described by carefully studying the performance of

unusually competent performers. A positivist philosophy describes professionals as technical problem solvers, problems being solved purely by the application of scientific theory. Schon describes the process whereby the professional solves problems as one of reflection, in which the professional uses and develops the arts described above (Schon, 1987). He states that the problems professionals face in the real world are seldom easy to solve. They are often presented within a context where they can be unique, or multidimensional or overlaid with value conflict. Professionals cannot rely on simple decision making steps but must weave and craft their actions to suit the context.

Critical incident analysis- or narrative are two examples in which reflection can be articulated. Benner (1984, in Rich and Parker, 1995) used critical incident analysis as a reflective tool to explain the link between art and science. Davies(1997) used narrative as reflection to describe the development of professional competence in student midwives. It is assumed that these techniques may be ways of identifying skilful or unskilful behaviour, providing a snapshot or vignette of practice. The MSRP uses its 'special cases' as one way for the midwife to articulate and reflect on her practice. These processes illustrate ways in which reflection can highlight areas of special expertise or areas of difficulty.

Skills for reflection.

In order to engage in reflection certain cognitive and affective skills are necessary. Aitkins and Murphy(1993) reviewed the literature on reflective practice. They identified five skills as being particularly relevant: These are: self-awareness, description, critical analysis, synthesis and evaluation.

> *"Self awareness enables a person to analyse feelings. This is an essential component of reflection. It involves an honest examination of how the situation has affected the individual and how the individual has affected the situation. Description involves the ability to recognise and recollect accurately salient events and key features of an experience.... Critical analysis involves examining the components of a situation, identifying existing knowledge, challenging assumptions and imagining and exploring alternatives. Synthesis is the integration of new knowledge with existing knowledge... and evaluation is the making of judgements about the value of something."* (Aitkins and Murphy, 1993,p.1190)

Within the MSRP each practising midwife will present for review with varying degrees of reflective ability, and indeed the ability of the panels to assist the midwife in this reflective process may also vary. The training for the panels and for the midwife will play an important role in facilitating a reflective process. Experience is another factor. One of the NZCOM review facilitators described the development of some midwives over the successive years of review. She stated that sometimes it can take three years

of reviews for some midwives to develop skills required to make best use of the process.

Kinds of reflection

Schon discusses two aspects of reflection. The first is reflection-in-action which occurs at the moment of action. Previous experience and knowledge interact within the particular situation using intuition and artistry. Reflection-on-action occurs after the moment. The practitioner comes to understand and learn from the situation by exploring the experience. This leads to a change in perspective or a greater understanding of the incident. It is reflection on action that we look at when we analyse the MSRC process. Reflection-in-action is poorly researched. The actual processes of what occurs are not clear.

Clarke et al propose two levels of reflection. Deliberative reflection

> *"involves planning, preparing, analysing, synthesising, predicting and evaluating. These important reflective processes require practitioners to draw on both their knowledge of the context in which they are working and their non-contextualised professional knowledge."* (p177).

Deep reflection, on the other hand reveals how we know what we know and

> *"...allows us to consider all aspects of practice, including the processes of deliberative reflection, and to ask fundamental questions about the underpinnings of practice. Deep reflection has the potential to enable practitioners not only to learn about nursing and thereby improve their*

practice but also to learn through nursing and thereby enhance their understanding of themselves" (ibid. p 178)

Goodman (1984 in Rich and Parker,1995) distinguishes between three levels of reflection.

> *"She views the first level as being concerned with the techniques and practices needed to achieve determined objectives. The second level is when the practitioner shows awareness of the implications of both personal and professional values and beliefs in relation to actions and makes explicit the rationale which governs them. At the third level practitioners acknowledge the wider issues, such as ethical and political concerns, demonstrating an understanding of how broader social forces can influence the course of their work* (p.1052).

The review process is such that it is flexible enough to allow for any level of reflection that the midwife is comfortable with yet allows the panel the flexibility to be able to extend her reflection. Many accounts of reflective practice (cited in Johns 1995) emphasise the difficulty of reflecting alone and suggest that practitioners need guidance to facilitate learning through reflection. The lone practitioner may attend to the experiences which are disturbing without attending to some of the more 'mundane' day-to-day events. A reflective guide can assist in selecting what factors need to be reflected upon and can focus on what factors within the experience need attending to.

Advantages of reflection

Why bother to reflect? When life for the midwife is busy and stressful enough what is the advantage for her in pausing in her working life to reflect? What benefit is it to the midwifery profession? For Clarke et al (1995) reflective practice is a way of integrating theory and practice. They describe eight benefits of reflective practice:

Table 5:1 Benefits of Reflective Practice. (Clarke et al, 1995, p. 175)

- To make sense of the experience
- To make clear professional judgements
- To improve practice
- To be valued and supported
- To generate theory
- To recognise biases, prejudices, learned values and assumptions
- To empower practitioners, enhancing their professional autonomy.
- To illustrate practice to other practitioners (p.175).

Johns (1995) discusses the need to establish a culture of reflection, where reflective practices are part of the every day working environment. He stresses that this shouldn't be compulsory as it would defeat the purpose entirely. The NZCOM would agree with him. They have stressed that they do not want the review process to be compulsory but would like to see it incorporated into how a midwife practices. At

present in the various regions around New Zealand there is a wide variability in pick up rates of those being reviewed. Some regions have been able to incorporate it into their local cultures. Others have not. Trying to establish what has made the difference could be part of a national evaluation..

Certainly the MSRC process is a way of formalising reflection as a peer review, quality assurance tool. Hogston (1995) suggests that formalising the reflective process may be one way to satisfy managerial concerns for measurable outcomes to quality. He proposes;

> *"Nurses are in a unique position to develop formalised peer support groups within an auditing programme which utilises reflection as a foundation. This could prove to be an exciting challenge for nurses in the future".* (p.169.).

Midwives have done just this with the development of the MSRP. It is however important to note that the very process of reflection may in fact threaten the very process of organisational stability as the practitioner tends to question the definition of the tasks in hand and eventually the measures of performance by which she is controlled.

The pitfalls of reflection are that there is actually scant evidence for establishing it as a powerful learning tool. Some concern could also be expressed about what could happen to a reflective tool should managers get hold of it. The process can lead to a large degree of self exposure where vulnerabilities are revealed. Measures should be taken to protect the midwife from any damage during this process and from misuse of

the information revealed.. The training of the reflective partners is also crucial. These people could be either very effective or particularly damaging.

Reflective practice is however increasingly popular as a framework for practitioners to evaluate their work. This is illustrated in the growing body of published material on it. It would be useful to research the nature of the reflective potential within the MSRC. This could develop future understandings of the value of reflection for practitioners.

> *"Understanding the factors that enable reflective practice to either flourish or cause it to flounder is a crucial issue that will require considerable attention if reflective practice is going to emerge from the rhetoric of expectation"* (Johns, 1995, p.23).

Supervision

Before going on to describe the how issues covered by the term 'supervision' relate to the Midwives Standards Review Process it is useful to clarify what the term actually means. This is because there seems to be different understandings of the word. For some, supervision is associated with the more negative process of disciplinary dealings between managers and their staff. It involves control over employment status and is concerned with the maintenance of standards (Butterworth, 1992, p.9). This is often referred to as 'managerial supervision'. Supervision can also be understood as the purposeful relationship between a professional and a trained supervisor for the purpose of expanding knowledge base, developing clinical proficiency and developing autonomy and self esteem (Platt-Koch, 1986 cited in Butterworth and Faugier, 1992). This I will refer to as 'clinical supervision' and has been modelled on the supervisory relationships found within the disciplines of social work and counselling. Between these two extremes are any number of models developed by different health practitioners to meet their own needs.

Within midwifery in New Zealand it is this second aspect of supervision which has most relevance particularly as most independent midwives are self employed and do not have a manager. Although the MSRP does not involve the development of a relationship it is trying to achieve much of the same outcomes as clinical supervision is. Its stance is to stress the reflective nature and the confidentiality of the process. The question one might ask is how able is it to achieve some of the goals of clinical

supervision without this relationship and how skilled are the members of the review panel in dealing with some of the issues that are raised?

Clinical supervision has the potential to facilitate deep reflective practice . What it may facilitate also is a process of personal exploration, the ability to work with the interpersonal and intrapersonal issues. However it needs to be provided in a safe environment.

> *"Reflective practice enables practitioners to look back over reflected experiences, for example every 6 months, and analyse their self-development in areas of practice. This can be documented as a 'reflective review' to demonstrate the development of significant or negotiated areas of development supported by experiences that illustrate this development. In this way the value of reflective practice as an organisational structure becomes evident. However, this also suggests the potential abuse of supervised reflection as a form of managerial control"* (Johns, 1994, p.28).

As mentioned in Chapter Four, midwives in the UK have a process of statutory supervision. Within this model the supervisor of midwives is meant to provide both a controlling and supporting role and is often the manager of the midwife being supervised. Certainly for New Zealand midwives the notion of having ones practice as tightly controlled as this goes against the notion of autonomous practice. Demilew's study of independently practising midwives in the UK found that *"The midwives clearly and powerfully articulated supervision as being usually practised in a controlling obstructive way* (Demilew, in Kirkham,1996, p.195).

One of the core questions in this context is: in whose interest is the supervision being exercised? In the NZ context, the answer to this question has changed over time. Originally it was seen as being of primary interest to the mother, the midwife's needs

being secondary. Now the focus has changed somewhat. It can be compared somewhat with the midwife who cares for the baby by nurturing and supporting the mother. So too does the College of Midwives as an organisation care for the mothers - by supporting and nurturing the midwives.

What will happen then if the review process becomes seen as the tool by which the profession is regulated? Will we become dammed if we do and dammed if we don't? True reflective practice may become impossible within this environment and midwives may be left having to undergo individual clinical supervision as their only means of support and growth. It would be a great loss to the profession when reflective practice becomes unsafe and the supervisory relationship becomes an obstructive one. It would be ironic if, as the supervisory relationship in the UK began to embrace the notions of reflective practice and peer review, midwives in New Zealand exposed their process to the restrictive and oppressive practices that go with professional regulation.

Competence

Competency based assessment is a process which has been principally linked with training and formal education. Within this system, student assessment becomes 'decoupled' from the particular institution or learning programme (Wolf, 1995). Its origins and principle protagonists are within the American education system, but its effects are spreading world-wide. Within the UK it is commonly known as National Vocational Qualifications (NVQs) and in New Zealand as the Qualifications Framework. Put simplistically the system breaks down a job into units of competence, all of which are required to perform an employment function (Worth-Butler et al 1994, p227).

Within this traditional approach to competence-are three assumptions:

> *"1. The emphasis on outcomes - specifically, multiple outcomes, each distinctive and separately considered.*
> *2. The belief that these can and should be specified to the point where they are clear and 'transparent' - that assessors, assessees and 'third parties' should be able to understand what is being assessed, and what should be achieved.*
> *3. The decoupling of assessment from particular institutions or learning programmes."* (Wolf, 1995, p2)

Although this process has been developed principally for training and education, the principles and processes have been extended into the workplace of both trades and professions and proposed as a method of quality assurance or recertification. Within

New Zealand this is reflected in the development of recent legislative changes around professional registration. The Medical Practitioners Act 1995 has given the Medical Council of New Zealand the responsibility to monitor and ensure the competence of all doctors registered in New Zealand. (Large,1997) This is seen as a trend setter. It is anticipated that all professional groups who have legislative requirements for registration will also have some legal requirement for the illustration of on-going competence.

International trends

Midwives throughout the world have developed different ways of establishing competence. The American College of Nurse-Midwives has developed a task analysis approach to the assessment of professional practice (Fullerton, 1988). They have used this approach to establish professional recognition in an environment unfamiliar with midwifery. It is used as a way of constructing nurse-midwifery as a profession. It uses a methodology of task analysis, breaking down the job of midwifery into 334 tasks. Each task has specified procedures and expected outcomes (Ibid.).

Midwives in the United Kingdom are faced with the problem of how to use NVQs as an assessment tool within their profession. At present NVQs are used in 'lower level' occupations and involve a similar task analysis approach as do the American nurse-midwives. For UK midwives the issue has arisen as to the appropriateness of this task analysis approach for the assessment of 'higher level' professions. Le Var's (1996)

review of the literature around the appropriateness of NVQs reveals that there is significant criticism of the NVQ process.

> *"As can be seen, several references focus on the problems of reductionism desegregation and fragmentation. It would appear that, regardless of the level of NVQs, these problems have the tendency to result in an assessment structure and process which emphasise the separateness of individual tasks and do not encourage analysis, synthesis or a holistic approach, linked to the discernment and development of theories, principles and methods."* (Le Var., 1996, p. 86)

Professionals in Australia have developed a more holistic approach to competence.

> *"It allows incorporation of ethics and values as elements, the need for reflective practice, the importance of context and the notion that there is more than one way of practising competently. Assessment methods are used in an integrated manner seeking to combine knowledge, understanding, problem-solving, technical skills, attitudes, and ethics in assessment."* (Le Var,1996,p. 90)

The ANRAC Nursing Competencies Framework was developed in Australia in 1990 to create national competencies for nurses. Assessments are made in eighteen areas including the nursing process, knowledge base, communication skills, compliance with the law, professional behaviour, ethics and research. It investigated modes of assessment for the assessor involving sources of evidence and cues to aid in measurement The NZCOM used this framework at its 1994 Standards Review working party to illustrate how the Standards of Practice could be assessed. (Davies,1997,p58)

The New Zealand scene

In New Zealand it is the Nursing Council which is the statutory body responsible for the regulation and registration of midwives. It is now committed to the establishment of competency based practising certificates by the end of the century (Nursing Council of New Zealand, 1997). A 1995 working party comprising practitioners, educators and administrators gathered to develop midwifery competencies. They gathered in an environment which was very resistant to placing midwifery education within the New Zealand Qualifications Framework. This framework would break midwifery education down into very small isolated units. They were determined that this would not happen, so instead used the NZCOM's statements on a Code of Practice, Code of Ethics and Standards of Practice as a framework for establishing competency (NZCOM, 1993). These standards had been prepared over a number of years consulting widely with midwives, consumers, and educators.

> *"The working party concluded that these Standards of Practice are very rigorous, encapsulating the essence of Midwifery Practice. These core competencies describe the fundamental knowledge, skills and behaviour expected of all registered midwives, therefore further development was unnecessary"* (Davies,1997,p. 73).

These ten core competencies for midwifery education therefore reflect closely the ten standards prepared by the NZCOM. It is these standards also which are a central to the Midwifery Standards Review Process and represent the core competencies which

New Zealand midwives use in establishing on going competency as practising midwives.

The Standards of Practice are not expressed in terms of minimum standards, they are standards of excellence, so there is no pass/fail point. This has been a deliberate decision by the NZCOM. It is expected that a practising midwife, having voluntarily presented her practice for review will have her Annual Practising Certificate renewed. It will be seen as sufficient that she has entered this reflective and holistic process. This decision is currently still under negotiation between the Nursing Council and the NZCOM. It is also envisaged that midwives may have some alternative means for gaining a competency based APC. These have yet to be decided. This reflects the approach of the College that the MSRP should remain voluntary so as to protect its reflective nature and to ensure that midwives choosing the College process are more likely to be committed to the midwifery model and to professional development. This is envisaged as a way of enhancing the validity of the process.

Philosophical positions on competency

These examples of varying ways of establishing and assessing competency reflect a wide variation in their philosophical positions. On the one hand we have the reductionist, objectivist approach in which competency is seen a way of controlling practitioners. It sees competency as being able to be clearly measured and expressed. It is essentially conservative with little room for creativity or alternative meaning. It relies on the development of minimum standards which may in the end lower the

overall standards of practitioners. Re-certification using this paradigm may simply be a time consuming process of going through the motions instead of focusing on real development as a practitioner.

The alternative is a postmodern constructivist approach in which reality is socially constructed. Knowledge is based in experience which is created, not discovered. Enquiry which includes investigation into competency is then essentially qualitative and experiential. The MSRP has positioned itself clearly within this paradigm, and takes a clear feminist approach to the nature of midwifery. In rejecting a pass/fail point it acknowledges the multiple realities of the worlds of both the midwife and the woman.

> *"Emphasis should be placed on the assumption that knowledge is gained through the formation of personal and social constructions. These are derived from personal experience and social interaction and are therefore nebulous, exhibiting many 'truths'."* (Goding, p158)

Worth-Butler et al, (1994) reviewed these different conceptualisations of competence and presented a model where both the quantitative and qualitative models are utilised.

> *"Competence involves the mastery of requirements for effective functioning, in the varied circumstances of the real world, and in a range of contexts and organisations. It involves not only observable behaviour which can be measured, but also unobservable attributes including attitudes, values, judgmental ability and personal dispositions: that is - not only performance but also capability* (pp226-7).

The problem of legislation for competence is that programmes designed to improve everybody may in fact leave behind those failing. Do we want to develop a system of checking up on the poor practitioners which puts adequate practitioners in repetitive,

time-consuming processes? Harlen (1995) points out that assessment is not an exact matter, can never be, and if we try to treat it as such we may damage the very learning we are striving to bring about. Emphasis should be placed on credibility, acknowledging the importance of sensitivity, conceptual ability, creativity and insight. The problem does remain however of how we deal with the at risk group. The premise is that the majority of midwives have a standard of practice that is acceptable. The NZCOM has developed a position that poor practitioners may benefit from the review process as much as adequate ones may. They then leave their complaints process to deal with the at risk group should difficulties arise. The Nursing Council in the end remains the only formal disciplinary body in New Zealand. It is hoped that when the Nurses Act comes up for review a separate Midwifery Council will be created.

Competence and partnership

It has been a fascinating process to look back at the developments and modifications made to the review tool over the past ten years. At successive local and national meetings the aims have been developed and clarified. The review process started out looking very much at a being a controlling body, then into trying to develop pass/fail points with debate on how to decide if a practitioner was meeting standards. This was done with little theoretical research although many midwives who assisted in the process were teachers and postgraduate students. What has been interesting to note is that the review process has moved from the objectivist approach towards a clear qualitative, feminist, philosophical position with an understanding of midwifery as a complex social and personal process. I think this reflects how securely entrenched for

midwives and the consumers who worked with them are the notions of partnership and feminism, and how clear midwives feel about their role, despite strong societal pressures which work against them. The battle they fought for autonomy has been a radicalising experience for many and the lessons are not easily forgotten. A clear understanding is retained that we still live in a patriarchal society following men's ways of knowing and understanding. This approach to professional development and competence would I think be incomprehensible to a large number of people working within the Western male paradigm. What has been clearly rejected is the centrality of the positivist quantitative approach which has been seen as unsuitable for furthering the understanding of complex, changing human behaviour. The end point of the review process so far has reflected in a pure form that midwives and consumers have claimed and continue to claim the validity of women's ways of being and knowing. In presenting the review process to the national regulatory body as a way of formally establishing competence they state a claim for this way of knowing to be accepted. In traditional terms competence is not measured by this process but the NZCOM have decided to manipulate the regulatory requirements to meet professional needs, to support and empower each other; midwife to woman, woman to midwife, midwife to midwife, woman to woman.

CHAPTER SIX: FUTURE DEVELOPMENT.

Competency based practising certificates

The MSRP has yet to be adopted by the Nursing Council of New Zealand as evidence of competency for the granting of practising certificates. As there is no pass/fail point with minimum levels of practice or of ongoing education there may be some difficulties with its adoption. The NZCOM is however keen that the review process be accepted as is, given that the process as it currently exists is thought to facilitate open and honest reflection. To protect its reflective nature it is seen that other alternatives for attaining competency based APCs .may be developed, possibly by other maternity provider organisations. This will enable the Colleges review process to remain voluntary which is seen as imperative. Negotiations are ongoing.

Uptake

It is of some concern that it is only a minority of midwives who make use of the review process. It has clearly not yet been accepted as normal practice within the midwifery culture. It is thought that with the requirement for competency based APCs the uptake will improve. Continued information sessions and proactive contact with midwives may also change the situation. Certainly as the culture of health professionals takes on

the concepts of accountability and as consumers require evidence of this midwives may make more use of the process and appreciate what it can provide.

Reflective practice

My study into the nature of reflective practice highlights that as a concept it has been poorly researched. Little has been illustrated about how it actually works in practice and what facilitates it The MSRP offers an ideal setting in which to describe in some detail what the nature of reflective practice is and how it can best be articulated. I also remain unsure as to how truly reflective midwives are or can be given the current structure of the MSRP. When compared with the process of clinical supervision as articulated in Chapter 5 it would seem that the nature of the reflection within the MSRP may take a different, more clinical bent. However the review process needs further research to ascertain whether it is being used by the midwives for reflection or even in fact whether they want it to be used this way. Research may then increase the validity of the MSRP as a reflective tool and add to the theoretical body of knowledge about the nature of reflective practice.

Substandard practice

As the MSRP developed, attention has been focused on the aspects of professional development and reflection. Within this framework little attention has been given to the matter of unsafe practice. As it exists at the moment the panels can identify unsafe

practice and plan with the midwife to attend to it. There is however no guarantee that the midwife will follow the plan. If the unsafe practice continues the panels do not have guidance as to where to go next, apart from refusing to review the midwife again. This is also true if the midwife's practice is illegal or unethical. The NZCOM needs to debate this issue further and provide some clearer guidance for the review panels. It is the perception of those in the wider health sphere that the review process will provide some protection for the consumer. Given the medico-legal environment in which we all work and the large quantity of negative publicity about midwives in the media, it may be advisable for the NZCOM to further clarify this role.

Training and expertise of panels

Concern was expressed by several participants in this study about the training and expertise of the review panel members. The NZCOM needs to be attentive to the learning needs of panel members, both midwives and consumers, so that they know what to look for, how to ask the right questions and how to balance support and challenge. If the review process develops into a more formalised procedure when linked to APCs, the constituents and expectations of the panellists may change radically.

Core midwifery

The MSRP pays no attention to the development needs of midwives working within hospitals who do not carry a case load. These are the midwives who work on a shift system within one defined area, e.g., delivery unit. To a certain extent they undergo the usual staff appraisal process within their management structure. However they often feel undervalued as midwives. It may be advisable for the NZCOM to develop a review process for these midwives.

National standardisation

Although there are local variations in the way midwifery is provided it is seen as important that there is national consistency about the way the MSRP is used. This is especially so given the advent of competency based APCs. It would seem timely to undergo a national evaluation of the MSRP, both to assess that its processes are consistent and relevant and that its outcomes compare well with its aims and objectives.

CHAPTER SEVEN: CONCLUSION

Using Robert Stake's (1995) case study methodology this study has described the Midwives Standards Review Process in some detail. It has placed the process within an historical and political context in which midwives have regained the legal right to practice autonomously, and within a health environment increasingly demanding professional accountability and consumer participation.

The MSRP in Wellington was used as 'the case' for the study. Stakes methodology is designed to capture the complexity of the single case and encourages the researcher to present the reader with a vicarious experience of the case. It allows for the identification and exploration of relevant issues and emphasises interpretation rather than generalisation.

The initial aims of my research were:

- To give an historical account of the review process.
- To describe the current review system including its aims and functioning.
- To discover how participants feel about the process including its strengths and weaknesses and how they feel it should develop in the future.
- To explore the relationship between the review system and the current health structures.
- To examine any policy documents relating to practice review.
- To establish whether training or preparation is necessary or sufficient.
- To assess the adequacy of resources.

- To highlight any areas for development or improvement.
- To compare the system with any others which have been developed for review of independent practitioners.
- To identify issues to be developed or included in a national review.

The study identified the MSRP as an innovative addition to the ways peer review and quality assurance can be provided for independent health practitioners. Of particular note are the involvement of consumers as equal participants in the review process and the emphasis on reflective practice within a supportive educative process.

Within the study the issues of most importance were identified as: quality assurance, reflective practice, supervision and competence. A central question highlighted by these issues is whether or not accountability and reflection can both be facilitated within the same process. The methodology of this study enabled the identification of this question. What is now required is the research to answer it. Although this study was able to provide a picture of how the participants of two reviews felt about the process, further research is required to give a clearer picture of the general perception of the process, with particular focus on the issues of accountability and reflective practice and whether or not they are being or can be provided together.

By the year 2000 midwives in New Zealand will be required to provide some evidence of competency before they have their annual practising certificates renewed. The MSRP is likely to be one avenue for gaining these certificates. The numbers of midwives seeking review are likely to increase. This has implications both for the training and expertise of the panellists and the for number of panellists required.

Although this was not identified within the study as an issue of current significance it is likely to become so. The availability of panellists in sufficient numbers and with appropriate expertise may stretch the resources of both the midwives and the community.

A national study is required to identify the usefulness of the process for midwives, in particular the role it plays in ensuring professional development and accountability. It would also need to take into account the anticipated legislative requirement for competency based annual practising certificates and assess the availability of appropriate resources to undertake this task within the current model.

CLOSING VIGNETTE

A personal reflection.

I have found that the describing of the Midwives Standards Review Process has been a fascinating experience. I freely acknowledged that I did not begin this study as a disinterested observer and recorder but as someone who has been very involved in both its beginnings and its development. I suppose I thought I knew the issues well. Along the way though, I have looked at it from many perspectives. At different stages of the journey, both in my reading and in my interviewing, my focus has shifted back and forth between viewpoints as issues have arisen and viewpoints and concerns have been raised. My beliefs about where it should develop and concentrate have often changed. Sometimes they have come a full circle. The end product presents a picture of a process which is dynamic and responsive both to the needs of the midwives and to the requirements of the health environment. It also reflects the beliefs and strategies of the midwives and consumers who have been most involved in its conception. This study is simply a snapshot of the process. It will continue to change and develop as it has done since its conception within the home birth movement.

As it moves into the next century, the process will no doubt have more challenges to face, as current paradigms shift and the needs and expectations of mothers and their families change.

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