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Rejoinder to Smith, R., Leap, N. & Homer, C 2010, Advanced midwifery practice or advancing midwifery practice?

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Rejoinder

Smith, R., Leap, N. & Homer, C (2010) Advanced midwifery practice or advancing midwifery practice? *Women and Birth*. (23)

We are pleased that our paper, “Reducing the length of stay for women who present as outpatients to delivery suite: a clinical practice improvement project” has generated an important debate. Smith, Leap and Homer applaud the work of the midwives we reported on who are providing independent care for women when they present to delivery suite with pregnancy-related concerns. Smith et al have challenged us on the use the term ‘advanced practice midwife’. We realise that choosing to use the term ‘advanced practice midwife’ is contentious in that some senior midwives do not want to have different levels of practice within midwifery. Further, the midwives working in the model of care we evaluated were not providing continuity of care which is the model of care being promoted by Smith et al (2010) and by the profession; including ourselves. In our report we were writing about the real world of midwifery practice as it exists today. Midwifery exists under regulatory and legal frameworks, including industrial awards, which recognise higher levels of appointment and higher levels of payment. The majority of Smith et al’s (2010) discourse does not address the substance of our paper. Instead the Smith et al paper seems to use our paper as a spring board for a philosophical discussion about what, ideally, should be the role of the midwife and scope of midwifery practice. Further, Smith et al argue the importance of separating midwifery from nursing by not going down an advanced practice pathway.

In making their argument, that the midwives in delivery suite were not functioning at an advanced level, Smith et al (2010) refer to the full scope of the ICM definition of the role of the midwife to claim that the midwives in our quality assurance study were functioning within the full scope of midwifery practice. The ICM role of the midwife includes the phrase ‘the detection of complications in mother and child, the accessing of medical or other appropriate assistance’. It is this phrase that seems to be the key matter of contention. Whilst we accept that all midwives must be able to detect complications and access medical assistance, the delivery suite midwives did more than this; they ordered and interpreted tests, they made diagnoses (normally considered medical), and they prescribed treatments, including IV fluids: this type of practice is not standard midwifery. Smith et al (2010) are writing about some future ideal where they, argue, the skills of the midwives that we reported upon will not be unusual. Smith et al (2010) claim that all newly graduating midwives in the future will be able to: perform speculum examinations, assess bishops scores, independently order and interpret all relevant pathology tests, prescribe and administer medications and IV fluids, perform venepuncture and IV cannulation and test reflexes including the detection of clonus. This ideal state may or may not come about; we hope it does. In the meantime we want midwives who are currently practising at a level that is more advanced than is usual for beginning midwives, to be recognised and valued by their profession as having advanced practice skills.