Midwives’ responses to the changed registration environment in Australia: A case study

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This thesis is the result of doctoral research that investigated midwives’ responses to the changed regulation conditions after the introduction of a single national register for health practitioners in Australia in 2010. The *Health Practitioner Regulation National Law Act (2009)* legislated for universal statutory registration under one national agency, the Australian Health Practitioner Regulatory Agency (AHPRA). The move focused on national uniformity of registration standards across health practitioners and ensuring public safety through the development of a flexible, responsive and sustainable Australian health workforce that is suitably trained and qualified (AHPRA, 2010). This research is concerned with how the members of one national board, the Nursing and Midwifery Board of Australia (NMBA), made meaning out of the national registration renewal standards.

National registration created a number of new situations for midwifery practitioners that presented potential challenges and opportunities that need examination. A separate register for midwives meant that for some midwives this was the first opportunity to register as a midwife, without the need to also be registered as a nurse. Previous voluntary arrangements for registration renewal in some jurisdiction were made statutory at national level for all practitioners – namely, continuing professional development, and proof of competence in the form of a declaration of recency of practice, and insurance cover. Also, a new annotation on the midwifery register presented experienced midwives with the equivalent of three years, full-time practice across the full range of maternity services, the option of gaining eligibility status.

This study addresses the question, ‘How are midwives responding to the changed conditions for registration renewal to practice in Australia?’ In doing this, it also answers three sub-questions:

- How are midwives negotiating the tensions between opportunities and challenges that the current requirements present them with?
• How are midwives engaging in continuing professional development?
• What decisions are midwives making about continuing to work in midwifery or
  nursing services given the current registration renewal requirements?

As a new phenomenon there has been very little contemporary research on
matters related to midwifery registration in Australia, and hence no relevant published
information was available to assist in answering these questions. Outcomes from this
study have therefore contributed to the limited research knowledge in this area, to
extend understanding. Literature on midwifery registration is restricted to grey
materials that plot the historical developments within the nursing and midwifery
professions such as initial education reviews, maternity service reviews, and documents
outlining changes in statutory legislation and regulation standards.

As part of the study, a purposive sample of 24 midwives with different practice
experiences from a range of midwifery practice roles, positions, and philosophies were
recruited to a longitudinal case study. Individual and group interviews were performed
to engage participants in conversation about how they planned to meet the national
registration renewal standards. A longitudinal case study design facilitated examination
of midwives’ decision-making processes over the initial two annual registration renewal
phases.

The introduction of new standards for registration renewal in June 2010 meant
that nurses and midwives had to consider how they would meet the registration
renewal standards at the next registration point in 2011. The interpretations of these
midwives working in the field level of maternity services were created in a context of
change, and reflect the tension, confusion and contradictions during the early years of
the new registration process.

Shared midwifery beliefs underpin the decisions that have determined how the
participants responded to the statutory requirements for registration renewal.
Midwives’ decision making about their registration renewal has accentuated particular
aspects of midwifery practice, and nursing practice, and perspectives of differences.
Their narratives reveal that midwives are motivated by relationships when making
decisions about CPD and demonstrating competence for registration renewal (Gray et al, 2014).

Tendencies to categorise practice into activities and practice locations for registration renewal purposes (Gray et al, 2015) led to the construction of themes of rotation, restriction and extension (Gray et al, 2016). Some kinds of practice could be used to validate RoP, while others were seen as doubtful in terms of currency, competence and recency of practice. Interpretations revealed midwives’ perceptions about meeting the national registration standards, and highlighted contractual issues that had potential to cause work force issues. These findings were shared with the profession (Gray et al, 2014, 2015, 2016).

These findings not only reveal midwives’ perceptions about the new registration standards, but also what individual midwives may be thinking and doing in regards to the dynamic production and re-production of the midwifery profession. Professional categorisation helped to explain the findings. This study affirms that collectively midwives have the potential to affect midwifery practice and maternity services, and shape the profession.
## Outputs during candidature

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<thead>
<tr>
<th>Year /Month</th>
<th>Title</th>
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<tr>
<td><strong>International Presentations</strong></td>
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<tr>
<td>2014 June</td>
<td>How are midwives responding to the changed conditions for registration renewal to practice in Australia?</td>
<td>Presentation</td>
<td>Prague: 30th Triennial International Confederation of Midwives Conference; ‘Midwives: Improving Womens’ Health Globally’</td>
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<tr>
<td>2015 August</td>
<td>Midwifery Regulation in Australia; Motivating influence of practice values.</td>
<td>Presentation/Seminar</td>
<td>Ryerson University Education Program. Speaker series.</td>
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<tr>
<td>Abstract accepted</td>
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<td>Presentation</td>
<td>Toronto: 31st Triennial International Confederation of Midwives Conference; ‘Midwives Making a Difference’ 2017</td>
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<tr>
<td>Abstract accepted</td>
<td>Midwife, nurse or both? A case study examining midwives’ responses to a changed registration environment in Australia</td>
<td>Presentation on maintaining regulation</td>
<td>Midwifery Education for the 21st Century: Innovations in Education, Practice and Regulation The 5th EMA Educational Conference</td>
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<td>‘How are Midwives responding to the changed conditions for registration renewal in Australia</td>
<td>Poster presenting findings from the literature review</td>
<td>ACM Queensland State Conference. Griffith University, Logan campus, Gold Coast</td>
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<td>Use of objects in data collection</td>
<td>Presentation</td>
<td>Teaching and Learning week. University of the Sunshine Coast</td>
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<td>‘Midwives values reflected in responses to personal; memorabilia’</td>
<td>Presentation</td>
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<td>2013 April</td>
<td>Completing reflective practice for health practitioners to meet the RoP standard</td>
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<td>2014 February</td>
<td>Methodology of case study</td>
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<td>Research workshop. School of Nursing and Midwifery. University of the Sunshine Coast. Capers Conference in Brisbane</td>
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<td>2015</td>
<td>Gray, M., Rowe, J and M, Barnes</td>
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<td>Australian Health Review</td>
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<td>2015</td>
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<td>Midwifery professionalisation and practice: influences of the changed registration standards in Australia.</td>
<td>Woman and Birth</td>
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<td>2015</td>
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<td>Defining Recency of Practice</td>
<td>Australian Nursing and Midwifery Journal</td>
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Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from published or unpublished work of others has been acknowledged in the text and a list of references is provided. Furthermore, acknowledgement of permission for the reproduction of three published papers which present the findings of this study is provided by the publishers as appendices.

Signature  

Date
Statement of contribution of others

Supervisors

Principal Supervisor: Associate Professor: Jennifer Rowe, PhD, MPhil, Grad Dip Ed, BA, Dip Ed, RN.

Co- Supervisor: Professor Margaret Barnes, PhD, MA, BEd, RN, RM.

Ethical Approval: USC Ethics Approval No. (S/11/360)
Acknowledgements

I would like to start with thanking all the midwives who kindly gave their time to be interviewed over the course of this study, without whose generosity of time and shared experiences this research would not have been possible.

I would also like to thank my supervisors; Jennifer Rowe and Margaret Barnes for their suggestion to complete this PhD with publications. Their support in the creation, writing and submission process of the three papers that present my findings enabled me to make a contribution to the changing environment of midwifery registration in Australia. Their assistance in completing this thesis is greatly appreciated. I am thankful for the opportunity that was afforded me by the University of the Sunshine Coast for allowing me to pursue my interest in midwifery registration, and for the research grant which supported my data collection.

I have always embraced Ernest Hemmingway’s saying; “It’s good to have an end to journey towards; but it’s the journey that matters, in the end” (Ernest Hemmingway)

For the majority of this research study I have embraced the rollercoaster that represents the journey that a doctoral experience offers. I revisited the civility that comes with being a student again, and revelled at the opportunity to increase my knowledge. During my journey in completing this doctoral study I have learnt a great deal, this journey has taught me much more than just research and academic skills required to complete a dissertation.

This journey would not have been possible without the sustained devotion of my patient, loving husband and my big hearted beautiful daughter to whom I am indebted to for their enduring commitment and patience. Finally, I wish to thank my many peers who have shared my journey, for their continued friendship and moral support. I really appreciate it and wish them luck in their completions too.
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Glossary of Terms

A number of organisations are pertinent to the process of national registration of health practitioners and the regulation of midwifery practice. The following glossary of terms is provided to assist the reader to recognise and understand the different organisations involved and the common terms and abbreviations used in this thesis. The International Confederation of Midwives (ICM) definition of a midwife is included in the glossary. This definition is used by each country to determine the scope of practice of the midwife.

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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| Australian College of Midwives (Philosophy) | Midwife means ‘with woman’: this underpins midwifery’s philosophy, work and relationships. Midwifery  
• is founded on respect for women and on a strong belief in the value of women’s work, bearing and rearing each generation.  
• considers women in pregnancy, childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman’s life. These events are also inherently important to society as a whole.  
• protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society.  
• is a woman centred, political, primary health care discipline founded on the relationship between a woman and her midwife.  
• focuses on a woman’s health needs, her expectations and aspirations.  
• encompasses the needs of the woman’s baby, and the woman’s family, her other important relationships and community, as identified and negotiated by the woman herself.  
• is holistic and recognises each woman’s social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself.  
• recognises every woman’s right to self-determination in attaining choice, control and continuity of care from one or more known caregivers.  
• recognises every woman’s responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals. |
• is informed by scientific evidence, by collective and individual experience, and by intuition.
• aims to follow each woman through pregnancy, labour and birth and the postnatal period, across the transition between institutions and the community, so she remains connected to her social support systems; the focus remaining on the woman, not on the institutions or the professionals involved.
• includes collaboration with and consultation between health professionals.

(ACM, 2016 [https://www.midwives.org.au/midwifery-philosophy])

| Australian College of Midwife | The ACM is a professional membership body for midwives in Australia. The ACM has Five Strategic Priorities
• Enhance the recognition, value and visibility of midwives
• Support midwives to provide high quality care
• Strengthen the position of the ACM as the voice for Australian midwives
• Ensure the ACM is effective, responsive and viable
• Drive reform and innovation in Australian maternity services

| Australian Health Practitioner Regulation Agency (AHPRA) | AHPRA supports the National Health Practitioner Boards that are responsible for regulating the 14 health professions. AHPRA’s operations are governed by the Health Practitioner Regulation National Law Act 2009, which came into effect on 1 July 2010, as in force in each state and territory. |

| Australian Nursing Council (ANC) | Historical Australian Nursing Council introduced nationally consistent competency standards for initial registration. |

| Australian Nursing and Midwifery Council (ANMC) | The Australian Nursing and Midwifery Council Incorporated (ANMC) was the peak national nursing and midwifery organisation established in 1992 to develop a national approach to nursing and midwifery regulation. ANMC has produced national standards that are an integral component of the regulatory framework to assist nurses and midwives to deliver safe and competent care. The ANMC documentation has been adopted in 2010 and continues to be used by the NMBA. |

<p>| Australian Nursing and Midwifery Accreditation Council (ANMAC) | In 2014 the ANMC was rebranded the Australian Nursing and Midwifery Accreditation Council (ANMAC), which is responsible for accreditation of education programmes for the preparation of nurses and midwives and sets the standards for initial registration. ANMAC is not referred to in this document. ANMAC (2014) Midwife; Accreditation Standards 2014. Canberra. (sighted 4.4.16) [<a href="http://www.anmac.org.au">www.anmac.org.au</a>] |
| <strong>Council of Australian Governments (COAG)</strong> | In 2006 the Council of Australian Governments (COAG) committed to establishing a planned strategic reform of the health and higher education sectors to address the challenges that limited the capacity of health practitioners. In response to the recommendations of the Productivity Commission, “in March 2008 COAG members signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions to implement the National Registration and Accreditation Scheme (NRAS (National Scheme)) by 1 July 2010” (p.7 APHRA, 2011). |
| <strong>Competence</strong> | Defined by ANMC (2006) as the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area. |
| <strong>Competent</strong> | Describes a person who has competence across all domains of competencies applicable to the midwife, at a standard that is judged to be appropriate for the level of midwife being assessed (ANMC 2006). |
| <strong>Continuing Professional Development (CPD)</strong> | CPD has been defined by legal, regulatory and professional bodies. Under the national law that governs the operations of the national boards and AHPRA. All registered health practitioners must undertake continuing professional development (CPD). CPD is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives. The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities, and reflecting on the value of those activities (NMBA, 2010(a)). |
| <strong>Endorsement</strong> | “To be eligible for endorsement for scheduled medicines under section 94 of the National Law, applicants must be able to demonstrate they meet all the following requirements: being a currently registered midwife in Australia; being able to demonstrate the equivalent of three (3) years full time post initial registration experience as a midwife and evidence of current competence to provide pregnancy, labour, birth and postnatal care, through professional practice review; and have an approved qualification to prescribe scheduled medicines required for practice across that continuum of midwifery care in accordance with relevant State and Territory legislation” (NMBA, 2015). |</p>
<table>
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<tr>
<th>International Confederation of Midwives (ICM)</th>
<th>Definition of a Midwife</th>
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<tr>
<td>“A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery” (ICM, 2014 [<a href="http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/">http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/</a>]  )</td>
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<th>Eligible Midwife</th>
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<td>An eligible midwife must possess three linked requirements to demonstrate the requisite knowledge, skills, judgement, care and experience across the continuum of midwifery care:</td>
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<tr>
<td>1. Experience and currency of that experience demonstrated through working three years across the continuum of midwifery care in the last five years;</td>
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<td>2. Formal professional review of all aspects of that professional midwifery practice at regular intervals; and</td>
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<tr>
<td>3. Additional ongoing continuing professional development that supports the level of practice that a midwife endorsed as an eligible midwife will need to demonstrate upon initial endorsement and maintenance of ongoing endorsement. (NMBA, 2013; Nursing and Midwifery Office of Queensland, 2014)</td>
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<tr>
<th>International Confederation of Midwives (ICM)</th>
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<td>This organisation supports, advises and strengthens associations of midwives across the world. The ICM defines the scope of midwifery practice (ICM, 2005). There are currently 108 national midwives’ associations that are members of ICM, representing 98 countries across every continent. ICM is organised into four regions: Africa, the Americas, Asia-Pacific and Europe. Together these associations represent over 250,000 midwives globally. ICM is an accredited non-governmental organisation and works closely with the WHO, UNFPA, UNICEF and other organisations worldwide to achieve common goals in the education and training of midwives and the care of mothers and children (ICM, 2011, 2014).</td>
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<th>Medicare Benefits Scheme(MBS) and Pharmacology Benefits Scheme (PBS)</th>
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| The Health Legislation Amendment Bill 2010 amends the Health Insurance Act 1973 and the National Health Act 1953 to enable eligible midwives to request appropriate diagnostic investigations and also prescribe certain medications (PBS) for which Medicare (MBS) payments can be paid. National Law section 38(2) and 94, standards set out the qualifications and other requirements that must be met in order for an applicant to be granted endorsement to obtain, supply and administer scheduled medicines. An annotation on the midwives’ national register allows eligible midwives prescribing powers in their state or territory, and access rebates under the Pharmaceuticals Benefits Scheme for drugs they
prescribe to women in their care, to order and interpret tests. The eligible midwife needs to apply for a Medicare Provider Number (MPN), which allows them to offer care to women, for which women can claim rebates. Medicare rebates for women for midwifery care have been available since 1 November 2010.

<table>
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<tr>
<th>Mid PLUS</th>
<th>Mid PLUS is the Australian College of Midwives’ Continuing Professional Development (CPD) program, designed by midwives for midwives who are involved in providing care to women and babies, educating midwifery students, managing midwifery services, researching midwifery issues or taking time out for family with the intention of returning to midwifery practice. The Australian College of Midwives in their Continuing Professional Development Program: Mid PLUS in 2007 describe CPD as the ongoing, systematic process that all health practitioners undertake to review their practice, maintain competence and enhance their professional and personal skills and knowledge in order to ensure their ability to provide high-quality care (ACM, 2014). A minimum of 30 Mid PLUS points must be completed each year (1 hour=1 point) to receive a certificate that the midwife has completed the required amount of hours for that year. This can be used as evidence to the NMBA, for registration renewal.</th>
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<td>Midwifery Practice Review (MPR)</td>
<td>MPR is a structured activity to assist practitioners to reflect on their practice and identify professional development goals. There are three components to MPR; 1. A self-assessment and self-reflection exercise (preparing your synopsis) 2. A one-hour face-to-face discussion with a midwife and consumer reviewer 3. Guidance and support to help practitioners to create a professional development plan (ACM, 2014)</td>
</tr>
<tr>
<td>Midwife’s Scope of Practice as defined by the International Confederation of Midwives (ICM)</td>
<td>The International Confederation of Midwives (ICM) defines scope of practice as the activities midwives are educated, competent, and authorised to perform. Activities include, but are not restricted to, providing ‘support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care’ (ICM 2011).</td>
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</table>
| Nursing and Midwifery Board of Australia (NMBA) | The primary role of the boards is to protect the public and set standards and policies that all registered health practitioners must meet. The functions of the Nursing and Midwifery Board of Australia (NMBA) include:  
registering nursing and midwifery practitioners and students  
developing standards, codes and guidelines for the nursing and midwifery profession  
• handling notifications, complaints, investigations and disciplinary hearings  
• assessing overseas-trained practitioners who wish to practise in Australia  
• approving accreditation standards and accredited courses of study.  
The NMBA has established state and territory boards to support its work in the national scheme. The National Board will set policy and professional standards, and the state and territory boards will continue to make individual notification and registration decisions affecting individual nurses and midwives. NMBA functions are supported by Australian Health Practitioner Regulation Agency (AHPRA, 2012). |
| National Registration and Accreditation Scheme (NRAS) | The National Registration and Accreditation Scheme (NRAS) was introduced to unify the Australian health practitioner workforce. Establishment of the NRAS saw the introduction of a single national registration and accreditation scheme for health practitioners. The scheme was remarkable in bringing about national uniformity of regulatory standards across all health professionals (AHPRA, 2010-2011). The aims of NRAS include:  
• protecting the public by ensuring that only suitably trained and qualified practitioners are registered; facilitating workforce mobility across Australia; and enabling the continuous development of a flexible, responsive and sustainable Australian health workforce.  
Professions currently regulated under the NRAS are:  
• Aboriginal and Torres Strait Islander health practice  
• Chinese medicine  
• Chiropractic  
• Dental practice  
• Medicine  
• Medical radiation practice  
• Nursing and midwifery  
• Occupational therapy  
• Optometry  
• Osteopathy |
Each profession has a National Board, which regulates the profession; registers practitioners; and develops standards, codes and guidelines for the profession. The Australian Health Practitioner Regulation Agency (AHPRA) administers NRAS and provides administrative support to the national boards.

| Practice | Practice is defined as any role in which the individual uses their nursing or midwifery skills and knowledge. It should be noted that for the purposes of the ANMC Continuing Competence Framework, practice is not restricted to the provision of direct clinical care only. Being ‘in practice’ therefore includes using nursing or midwifery knowledge in a direct relationships with clients, and working in nursing and midwifery management, administration, education, research, professional practice, regulatory or policy development roles and any other roles which impact on safe, effective nursing or midwifery service delivery (adapted from Nursing Council of New Zealand, 2004) (ANMC, 2009; NMBA, 2010). |
| Recency of Practice | Nurses and midwives must have undertaken sufficient practice to demonstrate competence in their professions within the preceding five years. The NMBA have defined recency of practice as entailing at least three months clinical practice in the last five years (NMBA, 2010 (b)). This standard refers to the definition of practice as first defined by the Nursing Council of New Zealand (2004) Annual Practising Certificates, available at http://www.nursingcouncil.org.nz cited in ANMC (2009), and adopted by the NMBA in 2010 (see practice definition above). |
| Registration renewal | Registration renewal is the term adopted by the NMBA in professional documentation. The term re-registration was initially used at the start of this study as this term was taken from the lead of the Australian Nursing and Midwifery Council (2009) who used the term in the Continuing Competence Framework. Consequently, the term re-registration forms part of the title in two of the published papers. The terminology elsewhere in this manuscript has been changed to registration renewal to reflected accepted language since the introduction of national registration standards (NMBA, 2010). |
**List of commonly used abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulatory Agency</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CPE</td>
<td>Continuing Professional Education</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>RoP</td>
<td>Recency of Practice</td>
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</tbody>
</table>
Preamble

As a registered nurse, registered midwife, academic and student researcher, my research combines my interest in professional practice and the behaviour of practitioners - such as professional regulation and legislation. The impetus for this study stemmed from personal experience as a registered nurse during midwifery training, and later as a new graduate midwife in an environment where new registration renewal standards were being introduced in the United Kingdom (UK).

I first trained as a registered nurse in England, (UK) 1987-1990 and completed midwifery training as a post nursing certificate which lasted 18 months, from February 1993 to August 1995. During this time introduction of new registration renewal processes (United Kingdom Central Council (UKCC), 1990, 1991, 1993, 1995), which were meant to strengthen the midwifery profession and guarantee safe, effective care for the public occurred simultaneously alongside the implementation of recommendations from the Changing Childbirth Report (Department of Health, 1993). These affected the delivery of maternity services in the UK, and impacted on the midwifery workforce. Midwives were required to rotate across different areas of maternity services as part of the development of continuity of care models that were to become part of routine service provision.

The combination of the changed registration renewal standards and the changing requirements for midwifery practice impacted on the workforce, necessitating research into the needs of midwives (Page, Cooney, Graham, & Holliday, 1996; Laslo & Strettle, 1996; Mitchell; 1997). Personal anecdotal experience recalls the anxiety provoked by the doubts and concerns as midwives’ questioned their ability to meet the proposed changes. During my midwifery training I was in awe of the responsibility my midwifery mentors bore, and somewhat apprehensive about my ability to fill their shoes in a profession where there was a prospect that there would be very few of these experienced midwives with a wealth of expertise left in midwifery. My apprehension about practising as an autonomous midwife in the future stemmed from the deluge of experienced midwives who vacated their roles during the time of my training in 1993–
1995, as I witnessed mature midwives taking early retirement at this time, while others remained but questioned their long-term continuation in the midwifery profession.

Universal introduction of the national statutory registration renewal standards officially commenced in 1997, supported by the publication *PREP and You* published by the UKCC. By this stage national campaigns had distributed information in the form of workshops and conferences, and the majority of midwives accepted and embraced the professional portfolio requirements (UKCC, 1995). Nevertheless, I recall vividly the reactions of my mentor’s at the prospect of the introduction of statutory registration renewal requirements, and the widespread concerns over new professional development requirements.

My initial midwifery training instilled in me values of a midwifery philosophy that embodied the beliefs of continuity of care and women’s choice, and informed consent. Women were supported to choose where to birth: in the community or in hospital settings (home birth, water-birth, birth suite, theatre). My post-registration midwifery practice necessitated an annual supervision interview, at which I made a concerted effort to engage in negotiating my continuing professional development plans. This resulted in me working within a diverse range of maternity services, providing low-risk and high-risk care in hospital and community, in women’s homes within a paid employment model. Therefore, my perspective on midwifery could be seen as biased towards an employee-paid model. I have not worked in private midwifery practice.

In 2004, in preparation for immigration to Australia. I registered as a nurse, and endorsed midwife with the Australian Nursing Council and Queensland Nursing Council. I am now located within the Australian context, where I work as a midwife and a nursing and midwifery lecturer. Since relocation to Australia in 2005, I have practised as a midwife, clinically in the public and private maternity services and in an academic position in a higher education setting. Therefore, the change proposed in Australia in 2009 from jurisdictional registration to statutory national registration affected my professional registrations and practice. I was intrigued by the planned change in registration renewal standards, and chose to examine how midwives would respond to the changed conditions for registration renewal in Australia.
Chapter 1

Background and Context

The study reported in this thesis concerns the changed registration environment for Australian midwives that occurred in 2010 and their responses in the two annual registration renewal periods following the introduction of national registration. Registration and regulation of midwifery and nursing in Australia is not new. The first formal registration was introduced in Tasmania in 1911 (Bogossian, 1998). Since then many iterations at state level have altered the alignment of nursing and midwifery as separate or overlapping professions. The changes that occurred in 2010 mark a significant event in the registration of midwives in Australia, as The Health Practitioner Regulation National Law Act (2009) sanctioned the introduction of a national separate register for midwives.

In order to provide a context for the study that it describes, this thesis commences by explaining the changes that occurred in the regulation of health practitioners’ regulation and registration in Australia which led to the introduction of national registration and a separate register for midwives in 2010. The meaning and purpose of professional regulation are explained before the standards for registration renewal brought in for nurses and midwives in 2010 are clarified. To provide context, a brief overview is provided of key historical developments and events in the regulation and registration of nursing and midwifery in Australia, highlighting how historic legislative and professional regulation events aligned nursing and midwifery for registration, regulation and educational purposes, in turn shaping the practice of midwives in this country.

Introduction of the national scheme

Legislation defines the parameters of health professional conduct within each country. As a result of legislation, the Australian Health Practitioner Regulation Agency (AHPRA) was formed as the national regulation agency, with an aim to oversee the registration of practitioners in the majority of health disciplines. The Health Practitioner Regulation National Law Act 2009 (the National Law) is the national law by which the
National Registration and Accreditation Scheme (NRAS) for health practitioners was instituted (see appendix A for details of NRAS). The *Health Practitioner Regulation National Law Act (2009)* was passed separately in each jurisdiction of Australia in a staged approach. Table 1 shows when each state and territory introduced the Act. Western Australia was the last jurisdiction to adopt the new legislation. Implementation of the national law resulted in the ceasing of state and territory based regulatory bodies, and the adoption of national regulatory standards. The adoption of the *Health Practitioner Regulation National Law Act (2009)* in all jurisdictions meant that for the first time in Australian history nurses and midwives were governed by universal registration and registration renewal, standards.

Table 1

*Staged introduction of the National Registration Act in each jurisdiction 2008–2010*

<table>
<thead>
<tr>
<th>Year</th>
<th>Jurisdiction</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>National</td>
<td>Health Practitioner Regulation (Administrative Arrangements) National Law Act – (Health Practitioner Regulation Law Act, 2009) in each state and territory resulted in national boards appointed in each jurisdiction</td>
</tr>
<tr>
<td>2009</td>
<td>New South Wales</td>
<td>New South Wales Health Practitioner Regulation National Law Act (NSW) No 86a</td>
</tr>
<tr>
<td>2010</td>
<td>Australian Capital Territory</td>
<td>Australian Capital Territory Health Practitioner Regulation National Law (ACT) Act 2010</td>
</tr>
<tr>
<td>2010</td>
<td>Northern Territory</td>
<td>Northern Territory Health Practitioner Regulation (National Uniform Legislation) Act 2010</td>
</tr>
<tr>
<td>2010</td>
<td>Tasmania</td>
<td>Tasmania Health Practitioner Regulation National Law (Tasmania) Act 2010</td>
</tr>
<tr>
<td>2010</td>
<td>South Australia</td>
<td>South Australia Health Practitioner Regulation National Law (South Australia) Act 2010</td>
</tr>
<tr>
<td>2010</td>
<td>Western Australia</td>
<td>Western Australia Health Practitioner Regulation National Law (WA) Act 2010</td>
</tr>
</tbody>
</table>
Prior to the introduction of national registration, “85 health professional bodies in eight states and territories, were governed by 66 Acts of parliament” (Nursing & Midwifery Board of Australia (NMBA) 2010, p. 1). The introduction of a national registration scheme for health practitioners centralised registration. The governance of the previous 85 professional bodies was consolidated and reduced to 14 national boards, plus a nationally consistent approach to the regulatory standards for initial registration and registration renewal requirements for 14 boards commenced.

Practitioners in dentistry, medicine, physiotherapy, nursing and midwifery, optometry, osteopathy, pharmacology, physiotherapy, podiatry, psychology, Chinese medicine, medical radiation, occupational therapy and Aboriginal and Torres Strait Islander health practitioners, are now regulated under one law (AHPRA, 2015). Each profession is then regulated by a profession specific national board. In the current context, AHPRA maintains the single, publically available register for 637,000 health practitioners across 14 professions (AHPRA, 2015). It functions in accordance with the NRAS Strategy 2011-2014 to ensure public safety through regulating health practitioners. AHPRA provides administrative and operational support to national boards to implement and administer the National Scheme in accordance with the National Law (AHPRA, 2010-2011; Snowball, 2014; AHPRA, 2015). AHPRA undertakes a number of functions, including managing registration and renewal processes for health practitioners and students and facilitating consistent standards and processes, and in some states it manages notifications regarding professional conduct, health and performance of practitioners on any of the registers. AHPRA also supports the functions of the professions’ national boards.

In 2010 the Nursing and Midwifery Board of Australia (NMBA) was appointed as the national regulatory body to control the registration of new nurses and midwives; and to monitor the registration renewal process. The NMBA defines the requirements that applicants, registrants or students need to meet to be registered. The functions of the Nursing and Midwifery Board of Australia include:

- registering nursing and midwifery practitioners and students
- developing standards, codes and guidelines for the nursing and midwifery profession
- handling notifications, complaints, investigations and disciplinary hearings
- assessing overseas trained practitioners who wish to practice in Australia
- approving accreditation standards and accredited courses of study.

(NMBA, 2015 (b)).
The significance of these events for midwifery and midwifery practitioners was that the change also introduced a separate register for midwives; thus separating nursing and midwifery registration and recognising each as a distinct profession (Health Practitioner Regulation National Law Act, 2009).

**The meaning and purpose of professional registration**

The primary function of professional regulation is protection of the public (Benton & Morrison, 2009; Health Practitioner Regulation National Law Act, 2009). The National Registration Agency Scheme (NRAS) has six objectives with the safety of the public being of primary importance: AHPRA ‘protect the health and safety of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered’ (AHPRA, 2010).

Nationally, and internationally, initial registration and registration renewal is a significant process used to regulate and monitor the safe practice of practitioners. Professional regulatory bodies set standards of practice, education, training, conduct and performance with the intention of ensuring high quality standards of practice and patient safety (ANMAC, 2014; NMBA, 2006; Nursing and Midwifery Council, (NMC) 2007, 2010, 2011; Midwifery Council of New Zealand, 2004, 2005). Registration with a professional body signifies recognition of competence to practice a given occupation or profession (Ellis, 2011). In Australia, individual practitioners must meet various competency requirements prior to initial registration to become qualified to receive a licence to practise. When midwives or nurses declare competence to renew registration each year they are declaring that they continue to meet the minimum standards of practice as set out by their professions’ competency documents (Nursing and Midwifery Board of Australia (NMBA), 2006, 2010, 2010 (a), 2010(b), 2016). The competency standards for practice identify the competencies the midwife must maintain as a minimum standard to continue to register as a midwife (NMBA, 2006). These benchmark statements are used to judge competence at initial registration, registration renewal, and in professional conduct matters (NMBA 2006).

To satisfy registration renewal conditions post 2010 changes, nurses and midwives in Australia must demonstrate their ability in standards related to Continuing Professional Development (CPD) (NMBA, 2010 (a)) and Recency of Practice (RoP) (NMBA, 2010(b)),
adequate insurance cover for scope of practice, and completion of a criminal history check (AHPRA, 2011; NMBA, 2010).

This study focuses on registered midwives’ response to this changed environment in the context of annual registration renewal. The two registration renewal requirements of interest to this research study are the CPD and the RoP registration standards which are specific to the disciplines, nursing and midwifery.

Continuing Professional Development (CPD)

The purpose of CPD is to maintain post-registration education and professional development in order to maintain competence and provide high quality services (AHPRA, 2010).

Ongoing engagement in CPD is seen as a fundamental activity synonymous not only for demonstrating ongoing competence but with being a professional, and a quality valued by all professions (Evetts, 2013). The need for ongoing education has a long history in nursing. It was encouraged by Florence Nightingale (1859) in the nineteenth century, who urged nurses to continue to learn. The requirement for ongoing education has remained an integral part of the agreed competency standards for nurses and midwives (Australian Nursing Council (ANC), 1992; ANMC, 2006; Homer, Passant, Kildea, Pincombe, Thorogood, Leap, Brodie, 2007). The credibility and status of a profession as a whole are enhanced through the updating of, knowledge, qualifications and competence (Ryan, 2003; Evetts, 2011).

National registration renewal standards in Australia have quantified the required amount of CPD activity. From June 2010, all health practitioners wishing to renew their registration with the relevant national board have had to declare completion of a sufficient amount of statutory hours of CPD (AHPRA, 2010; NMBA, 2010 (a)). In the case of nurses and midwives, the NMBA specifies the minimum requirements as at least 20 hours of CPD per year, for each register. CPD must be directly relevant to the nurse or midwife’s context of practice and practitioners with endorsements must complete additional hours to maintain the endorsement (NMBA 2010 ).

CPD activities are considered any activity that increases knowledge and skills. CPD activities can be classified as either self-selected by the individual (such as post-graduate courses) or mandatory training selected by the employer or in accordance with state requirements. Further details of CPD requirements are provided in Appendix (B).
Professional guidance documents in conjunction with each profession’s regulatory body, outline the standards for CPD. In 2010 the NMBA produced guidelines for Continuing Professional Development\(^1\). The document guides nurse and midwife practitioners on the selection and context for CPD, and promotes reflection as an activity that nurses and midwives should engage in to optimise their CPD and identify the benefits to their practice. Midwifery practitioners must take responsibility for deciding what CPD is relevant to them and prioritise their own learning needs based on self-evaluation of their practice against relevant national competencies for midwifery practice (NMBA, 2006, 2010). Reflecting on their individual learning needs presents an annual opportunity for practitioners to examine their aspirations, knowledge, competence and job satisfaction, enabling them to examine their current position and evaluate their practice annually. Practitioners need to document and verify all CPD evidence. (NMBA, 2010). Of interest to the present study was the approach taken to CPD by those midwives also registered as nurses, which was the majority in 2010, particularly how they might assign activities in one or both, portfolios.

Prior to 2010 the majority of Australian midwives needed to declare that they met registration renewal standards as a registered nurse (RN), according to the standards dictated in each state or territory, as midwifery was an endorsement on the nursing register. Of note was a complex situation which existed for midwives from other countries without a RN registration. This situation was problematic as there was no mechanism for registering them as a single-registrant midwife. Instead they were registered as nurses, with notations to limit their practice to midwifery (N3ET, 2006). Thus, at registration renewal they declared competency for their scope of practice (midwifery).

Recency of Practice (RoP)

Recency of practice (RoP) is about being able to demonstrate sufficient and recent practice knowledge and skills (Appendix C). In Australia since 2010 the RoP standard has required that health professionals (when seeking renewal of registration) must demonstrate that they have undertaken sufficient “practice” in their profession within the preceding five years to maintain competence (AHPRA, 2010)\(^2\). The NMBA practice definition specifies what

\(^{1}\) A new version of the Continuing Professional Development registration standard will be applicable from Jun 1, 2016.

\(^{2}\) A new version of the RoP registration standard comes into effect on June 1 2016
behaviour can be counted towards meeting the RoP standard. Specific to nursing and midwifery, sufficient “practice” has been quantified as a minimum of three months, full-time practice in the last five years, for each register (NMBA, 2010). The NMBA defines “practice”:

“Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a nurse or midwife. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.” (NMBA, 2010, p.1)

This standard enables practitioners practising one day a week to meet the requirement. However, practitioners unsure or unable to meet this standard are advised to contact the NMBA to complete a ‘program or assessment approved by the Board, or the successful completion of a supervised practice experience approved by the Board’ (NMBA, 2011, p.1).

The introduction of separate registers for nurses and midwives meant practitioners were asked to declare “that their nursing or midwifery skills are current and up to date” (NMBA, 2012, p.2) and show that they have “maintained an adequate connection with, and recent practice in, each registration” (NMBA, 2012, p.2). Dual registered practitioners were advised that if they thought an aspect of their work “could provide evidence for both nursing and midwifery practice, they could make a case” for that aspect counting towards RoP for both nursing and midwifery; the example given was “caring for women and their babies after having a caesarean section” (NMBA, 2012, p.2).

The introduction of a separate register for midwives recognised the distinctiveness of midwifery as a profession, indicating there was no longer a need to be registered as a nurse and endorsed as a midwife. The distinct focus of midwifery in contemporary Australia is captured in the ACM’s philosophy, (see the glossary of terms), which emphasises a holistic, wellness centred, and supportive relationship with women and their families, across the childbearing continuum.

The inaugural necessity to meet the CPD and RoP standards in each or both disciplines potentially had implications and impact for midwives in Australia and thus formed the focus of the present study. To provide context to the issues a brief background is given. An overview
of historical developments and events related to the regulation of midwifery in Australia, which led ultimately to the legislation which introduced national registration, will be discussed and issues raised by the changes will be highlighted.

The History of Regulation of Nursing and Midwifery in Australia

Registration is the main, but not the only, form of regulation of health practitioners. Professional regulation involves controlling standards of initial training, and ongoing standards of practice through registration of practitioners and membership of a professional association (Dawson, Brodie, Copeland, Rumsey, & Homer, 2014). The determinants of regulation identified by Dawson et al. (2014) in terms of professional associations, education, and registration and regulation provide a useful framework with which to consider the numerous aspects of regulation.

Before legislation to govern the practice of nurses and midwives, these professions engaged in self-regulation. This can be seen in historical documents that recorded regulatory behaviours before legislation sanctioned them and in the subsequent legislation that has shaped and defined nursing and midwifery in Australia. Table 2 shows a timeline of Australian events.

Midwifery in Australia has been self-regulated in some form or other since the beginning of the 20th century. As Table 2 shows, the first school of midwifery in Sydney started in 1877 at the Benevolent Hospital.
Table 2

Timeline of Registration and Regulation Events in Australia

<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1877</td>
<td>First record of self-regulation in Australia. The first school of midwifery started at the Benevolent Hospital, Sydney</td>
</tr>
<tr>
<td>1899</td>
<td>The Australasian Trained Nurses’ Association acted as gate keepers to the profession and offered voluntary registration for nurses and midwives</td>
</tr>
<tr>
<td>1911</td>
<td>First registration of midwives in Australia occurred in Tasmania and Western Australia</td>
</tr>
<tr>
<td>1912</td>
<td>Queensland - The Nurses’ Registration Board required trainee midwives to enter a hospital to secure a licensing certificate to practice.</td>
</tr>
<tr>
<td>1915</td>
<td>Victoria - Midwives Act – Introduction of a Midwives Board to register all midwives</td>
</tr>
<tr>
<td>1922</td>
<td>In Queensland - Centralising of nurses and midwives’ education in hospitals</td>
</tr>
<tr>
<td>1923</td>
<td>Nursing first regulated by statute</td>
</tr>
<tr>
<td></td>
<td>1923 – 1928 nursing and midwifery coexisted as separate professions</td>
</tr>
<tr>
<td>1939-</td>
<td>Nurses served outside their country in WWII</td>
</tr>
<tr>
<td>1948</td>
<td>The Health Services Act led to free care for all</td>
</tr>
<tr>
<td>1949</td>
<td>Formation of College of Nursing in Australia</td>
</tr>
<tr>
<td>1975-</td>
<td>The original Australian Nurse Regulatory Authorities Conference (ANRAC)</td>
</tr>
<tr>
<td>1990</td>
<td>Competencies, were widely validated and published in 1990</td>
</tr>
<tr>
<td>1984</td>
<td>1984 - Nursing and Midwifery education moved to tertiary</td>
</tr>
<tr>
<td>1992</td>
<td>The Nursing Act (1992) was amended to state; Section 74 (3) ‘a midwife who was not a nurse’. ACT NSW NT QLD SA TAS VIC WA made respective amendments to their respective legislation</td>
</tr>
<tr>
<td>1992</td>
<td>Australian Nursing Council (ANC) formed</td>
</tr>
<tr>
<td>1997</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Introduction of Bachelor of Midwifery programs</td>
</tr>
<tr>
<td>2006</td>
<td>Australian Nursing and Midwifery Council (ANMC)- name change for ANC and nationally agreed Competency standards introduced</td>
</tr>
<tr>
<td>2006</td>
<td>NMBA Competency Standards for the Registered Midwife and Competency Standards for the Registered Nurse (both rebranded 2010)</td>
</tr>
<tr>
<td>2010</td>
<td>National Registration introduced separate register for nurses and midwives (AHPRA 2010)</td>
</tr>
<tr>
<td>2010</td>
<td>ANMAC responsible for accreditation of programs leading to initial registration and re-entry programs</td>
</tr>
</tbody>
</table>
Historical events have had considerable impact on how midwifery as a profession is viewed in Australia. They show a long history of overlap between nursing and midwifery with midwifery often seen as a type of nursing specialty, despite the efforts of midwifery leaders to define the separateness and individuality of midwifery (Homer, Passant, Brodie, Kildea, Leap, Pincombe, & Thorogood, 2009; Leap, Barclay & Sheehan, 2003; Brodie & Barclay, 2001). The introduction of national registration in Australia was one further event that shaped the development of midwifery in Australia.

Professional associations registered nurses and midwives before legislation was implemented to direct the regulation of nursing and midwifery. In 1903, the Australasian Trained Nurses Association (ATNA) became the first professional association to provide voluntary registration for nurses, and midwives. Membership compliance was generated by peer pressure and desire for professional conformity (Summers, 1998).

The first registration of midwives in Australia occurred in Tasmania in 1911 (Bogossian, 1998; The Midwives Act, 2011). In the same year the “Nurses Board of Queensland I”, commenced registration of nurses on 31 December, 1911 (Queensland Government, (a)). A day later, on 1st January 1912, the Nurses’ Registration Board introduced the requirement that trainee midwives must enter the hospital in order to secure a practice license certificate (Davies, 2003). South Australia was the first state in Australia to implement legislation that incorporated the registration of nurses, midwives and mental health nurses together (Summers, 1998).

A Midwives Registration Bill was passed by parliament in Victoria in 1915 (Fahy, 2007). In 1916 in Victoria, a further Midwives Act protected the title “Midwife”, meaning that no one could perform the duties of a midwife without being registered. This bill introduced the establishment of a Midwives Board that was responsible for the registration of both vocational and formally trained midwives in Victoria (Fahy, 2007). Initially, midwives with a variety of qualifications were permitted entry to the register. For example, the inaugural register in Victoria included any midwife who could prove she had practiced as a midwife for the previous “two years in Victoria or any other state in the Commonwealth of Australia or within the Dominion of New Zealand” (Public Record Office Victoria, 2005). This meant that, initially, the register contained both formally trained midwives, vocational and lay midwives (Fahy, 2007).
Formally trained midwives also practised at different standards based on their level of preparatory training. Midwives with formal training were permitted direct entry to the 1915 register, whereas midwives with only one year of recognised midwifery practice could opt to complete an approved examination. These requirements present the first form of registration standards. By 1 January 1916, 1,921 women had provided evidence that permitted them entry to the register as midwives (Midwives Act, Victoria, 1928). Registrants were charged an initial registration fee (five shillings), and a subsequent annual registration renewal charge of two shillings and sixpence; failure to pay resulted in removal from the register (Midwives Act, 1928).

In 1923, the Nurses’ Act saw the introduction of the first Nurses’ Board in Australia in Queensland. From 1923 to 1928 nursing and midwifery coexisted as separate professions. However, the simultaneous passing of the Nurses Act (1928) and the Midwives Act (1928) consolidated the laws regulating nursing and midwifery. The Midwives Act (1928) repealed all previous legislation regulating midwives and removed midwives’ independent registration status by including midwives under the regulation of the Nurses’ Board in each respective state and territory (The Public Record Office Victoria, 2005). A Register of Midwives was kept under the 1928 Act for single registrants without a nursing qualification who registered in 1915 (Midwives Act, 1928). However, in most states, the midwives’ boards were abolished by the Nurses Act (1928). Consequently, for most of Australia’s post-federation history, midwifery has been seen as a subsidiary of a nursing qualification (Barclay, 1985).

A Board of Nursing was established in each state and territory by 1928 and these boards were deemed responsible for registration and training of nurses and midwives (Nurses Act, 1928). Each board was authorised to determine whether registrants from the midwifery register should complete supplementary training (Midwives Act, 1928), a measure most likely aimed at standardising the level of midwifery practitioner, based on the initial registration of vocational midwives in 1915. The nursing boards became responsible for midwifery training and determined who could be recruited, and where midwifery training could occur (Nurses Act, 1928). This governance structure introduced post-nursing registration midwifery training in Australia, and midwifery became an additional certificate or endorsement after initial nurse training (Nurses Act, 1928). Direct entry midwifery training ceased to exist.
From 1928 onwards, the nursing boards that had developed within each separate jurisdiction transitioned through many name changes over time. For example, in Queensland the “Nurses Board of Queensland I”, was responsible for the registration of nurses between 1911-1928 and transitioned to the “Nurses and Masseurs Board of Nursing Studies in Queensland” (1928–1965), then the “Nurses Board of Queensland II” (1965–1976), and then the “Board of Nursing Studies” (1976–1993), before becoming the “Queensland Nursing Council” (1993–2010) (Queensland Government, State Archives (a), (b), (c) n.d.). Similarly, name changes occurred in other state and territory nursing bodies. Nursing boards continued in one form or other from 1928 until 2010.

Between 1928 and 1948 several events impacted on the progression of regulatory developments and midwifery practice in Australia. World War II (WWII) (1939-1945) saw nurses either leave to assist in the war effort or support the delivery of short-staffed civilian hospital services. Barclay (2008) acknowledges that regular wages and the hospital working environment became familiar for midwives during WWII, leading to midwives remaining within the hospital system after the war. After WWII, a post-war baby bonus was paid to encourage population growth to build future economic stability. Births moved to hospitals with women convalescing for up to 12 days (O’Sullivan, 2006).

Post war 1948–1970s the continued movement of birth to hospitals, and increase in birth rate, staff shortages after the war, and the incorporation of midwifery into the nursing profession meant that birthing women in hospitals was a more economical use of the workforce, but also formalised nursing practices and regulated the practices of midwives (Barclay, 2008).

The history of nursing and midwifery regulation has been the source of much discussion due to the progression of different standards and conditions that historically existed between registration boards in Australia (Boggossian, 1998; Barclay, 1985; Brodie & Barclay, 2001; New South Wales (NSW), 2010). Nurses and midwives in Western Australia (WA) had the option of renewing their registration for practice every three years, while the remainder of Australian practitioners were required to register annually. However, in NSW and WA, a registered nurse with a midwifery endorsement could remain registered indefinitely as a midwife as the professional regulatory bodies for nurses and midwives had no recourse to take action unless a professional inquiry was initiated into their practice (N3ET, 2006; NSW Registration Board; 2010; Brodie & Barclay, 2001).
Legislation in different jurisdictions of Australia was amended between 1984 and 1992 to include the provision of registration of midwives without nursing qualifications. For example, in Queensland, the *Nursing Act* (1992, section 74 (3)) was amended to mention “a midwife who was not a nurse” (Queensland Government, 1992). The Nursing Act (1992) allowed midwives with a single qualification to register as a nurse with midwifery endorsement; even though they did not have a nursing qualification (N3ET, 2006). The endorsement contained practice restrictions to only practise midwifery (The Nursing Act, 1992; N3ET, 2006). This was the norm in Australia until 2002 when signs that there was a shift in thinking, resulted in the introduction of direct entry midwifery education programs being introduced in four states (Leap et al., 2003). In an analysis of the legislation and professional regulation of nursing and midwifery in Australia, only three jurisdictions provided separate registers for midwives with no nursing qualification, the Australian Capital Territory, New South Wales and South Australia (N3ET, 2006). Other states and territories persisted in recognising midwifery qualifications as an endorsement on the nursing register. Consequently, inconsistencies existed between jurisdictions.

In 1992, consistency in the form of nationally agreed standards of practice was introduced (Australian Nursing Council). The Australian Nursing Council (ANC), was the first Australian national nursing body with agreed standards of practice in the form of professional practice guidelines, codes of ethics and, professional conduct and competency standards. Reciprocal arrangements between jurisdictions became possible because regulatory bodies could agree on expectations around level of practice based on the ANC standards, enabling nurses and midwives to apply for recognition of qualifications across borders to practise. Furthermore, an agreement between the Australian and New Zealand national governments in 1997 enacted the Trans-Tasman Mutual Recognition Act which led to a signed agreement of mutual recognition, which enabled reciprocal practitioners’ agreements between these countries that persist to this day (Midwifery Council of New Zealand, n.d).

Despite the nationally agreed ANC competency standards for initial registration, inconsistencies in registration renewal standards persisted between states and territories. Variation in state and territory based regulatory regimes meant that practitioners were only able to practise in their jurisdiction of registration, and were required to apply for registration in another state or territory in order to move and practice (Productivity Commission, 2005; National Nursing and Nursing Education Taskforce (N3ET), 2006).
In 2006, a report written for the National Nursing and Nursing Education Taskforce (N3ET) reported on the variations in the details of registration of nurses and midwives in Australia, Amanda Adrian’s findings included the different time periods of registration renewal (N3ET, 2006). Inconsistencies were evident in the conditions that had to be met for CPD and recency of practice (N3ET, 2006). In some jurisdictions the midwifery registration was an endorsement on the nursing register; namely in Queensland, Victoria, Northern Territory and Tasmanaiia (N3ET, 2006). Each jurisdiction had their own standards, these varied from state to state, and territory to territory. For example, in Queensland, in 1997, the Queensland Nursing Council (QNC) introduced registration renewal requirements (QNC, 2005, 2008) which required nurses to make self-declarations to confirm their competence to renew their registration annually; these standards were later transferred to the NMBA in 2006. For example, in Queensland, the Queensland Nursing Council (QNC) required midwives to self-declare competence to renew their registration as a nurse, with an endorsement as a RN-midwife or as a direct entry midwife. (QNC, 2005, 2008). The competence declarations for registration renewal initially applied only to the nurse register and were not extended to the midwifery endorsements until 2007. This arrangement meant that between 1928 and 2007 midwifery practitioners in Queensland did not have to prove ongoing competence for midwifery practice registration purposes.

Variation in education, registration and regulation was not limited to the nursing and midwifery practitioners.

**NRAS and the Health Practitioner Regulation Law Act**

In a project commissioned by ministers at the Australian Health Ministers Conference in 2004, the Australian Government asked the Productivity Commission to investigate the issues impacting on the supply and demand of health practitioners and to propose methods to ensure a quality health workforce would be provided in the future. The Productivity Commission in 2005 expressed grave concern after reviewing the activities of 90 health practitioners and proposed to the government the introduction of a national registration board, supported by profession-specific national boards. In 2006 the Council of Australian Governments (COAG) committed to establish a planned strategic reform of the health and higher education sectors to address the challenges that limited the capacity of health
practitioners. In response to the recommendations of the Productivity Commission, “in March 2008 COAG members signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions to implement the National Registration and Accreditation Scheme (NRAS (National Scheme)) by 1 July 2010” (APHRA, 2011, p.7).

The Health Practitioner Regulation Law Act No. 45 of 2009 (The Act) was enacted to advance the objectives of the NRAS. The Act aimed to; "develop a flexible, responsive and sustainable workforce, and to increase the mobility of the healthcare workforce across borders by reducing the administration impact on healthcare practitioners and accommodating the surveillance of overseas-trained health practitioners through rigorous and responsive assessments. Finally, the Act promised to facilitate access to services from health practitioners in accordance with public interest” (Section 4, p. 27). For example, in responding to national maternity service reviews and workforce issues, the Act also introduced opportunities for midwives to extend their practice through meeting the requirement for a notation on the register as ‘eligible midwife’ which enables midwives’ access to the Medicare Benefits Scheme and the Pharmacological Benefits Scheme.

The National Registration and Accreditation Scheme (NRAS) was introduced as a single national registration and accreditation scheme for health practitioners to unify the Australian professional health workforce. Details of the objectives of the NRAS can be found in Appendix (A).

Significance of the changed registration environment for the present study

The majority of nursing and midwifery practitioners who renewed their registrations by their state and territory cut-off dates in 2010 automatically transitioned directly to the national register. Therefore, the first time they needed to consider their responses to the statutory national registration renewal standards occurred at the next registration renewal date in 2011.

The introduction of national legislation that applied across all Australian jurisdictions meant that practitioner boards standardised initial registration and registration renewal requirements, to be met by all practitioners. The changes to national registration have had implications for midwives as the new conditions present an opportunity for practitioners to reflect and examine their professional positions, their current practice role, and consider
their future plans in terms of service type and professional alignment. How the midwifery workforce has responded to the changed registration renewal conditions in Australia, is the focus of this research.

What the change to the national scheme provided was a new environment of consistency where annually nurses and midwives have to prove competence for each register. Previously midwives were required to maintain dual registration as a nurse to practice midwifery, however since 2010 midwives have had the option of renewing their registration as a midwife on the single midwifery register (The Health Practitioner Regulation National Law Act, 2009). Therefore, individuals must now declare competence for continued registration through declaration of meeting the CPD and RoP standards. Furthermore, the need to demonstrate competence separately for each register represented a new phenomenon for many midwives in Australia as the previous conditions for midwifery endorsement/certification on the nursing register required midwives to tick a box to confirm renewal for both qualifications. Declarations of competency in nursing practice could suffice for renewal of midwifery registration (N3ET, 2006; Brodie and Barclay, 2001; Bogossian 1998). Consequently, midwives have to make decisions about registration renewal competence as they reflect; Do I practise as a nurse? Do I practise as a midwife?

Aim of this study

To date there has been limited research regarding the implications of these national mandatory changes for practitioners, including the way that regulation and legislation might impact the professionals and their practice, or impact on workforce supply and services. For this reason, it is important to understand how midwives as health practitioners have responded to the changed regulation conditions and registration renewal requirements, the decisions they have made, and how their decision-making may impact on the services available to birthing women. Australia provides a perfect case study of what happens to practitioners when the registration environment changes.

The aim of this study was to address these issues by asking the questions “How are midwives responding to the changed conditions for registration renewal to practice in Australia?” In particular, this research study aimed to investigate the meaning schemas constructed by midwives in the unique context of Australian registration to show how midwives have engaged in the challenges of meeting the national registration renewal
requirements – specifically the CPD and RoP standards – and how these challenges have shaped their everyday perceptions and practice.

The objectives of this research were to:

Record midwives’ practice journeys as they experience the changed conditions for registration renewal, specifically to:

- Investigate how they navigate the competing issues which support or challenge CPD activity;
- Identify what midwives value, and what they see as important about their clinical practice and their continuing professional development;
- Identify midwives’ support needs for CPD.

Organisation of this Thesis

Chapter 2 presents a review of research literature relevant to the study aims. Chapter 3 introduces the research design and methodology. A longitudinal single case study design (Yin, 2009) was used. This chapter explains the rationale behind the decision to choose a case study design as well as the design and methods of data collection and analysis. Chapter 4 introduces the 20 participants who took part in the individual interviews to contextualise the findings. Participants were recruited nationally and represent four jurisdictions of Australia. The sample presents a diverse range of practitioners from both public and private maternity services. More specifically, the majority of the sample held dual registrations at the time of their recruitment into this study, and the sample represents practitioners in nursing and midwifery positions, with a range of practice experiences, practice roles and workplaces.

Chapter 5 presents the findings of the research in the form of three papers published in peer-reviewed journals. The journal publishers gave permission for the manuscript content to be used in its final form for publication. The findings of this research present contemporary knowledge about the impact of the changed registration standards on practitioners. Research findings were published contemporaneously. Publication 1 identifies the first round of findings - the motivational factors that underpinned the decisions midwives made about CPD selection. Paper 2 highlights the confusion around the recency of practice standard and the consequences for registration renewal and potential implications for workforce planning. Paper 3 examines the RoP standard and how this was interpreted by
midwives showing the influences of role, service type and everyday practice on understandings of nursing and midwifery as professions and implications for participants’ ongoing registration in one or both, registers. Chapter 6 consolidates and discusses the findings. The theoretical lens of self-categorisation and social identity theory assisted in explaining the findings particularly in terms of professional socialisation and professionalisation in midwifery in Australia post 2010.
Chapter 2
Review of the literature

The registration renewal process presents a point in time when individuals consider their options and make choices about revalidating their competence to renew registration as a nurse and/or a midwife. This chapter presents current knowledge about registration renewal and registration standards. It considers studies that shed light on midwives’ meaning schemes and behaviour related to registration renewal in order to inform the research objectives set out in Chapter 1.

There is a body of discussion papers, commentary, editorials and reviews produced and published by a range of stakeholder representatives addressing issues associated with altered registration processes. The current chapter draws on primary research sources.

In an attempt to gain understanding of the current situation, the review focused on two factors. First, an investigation of the impact of changed registration processes on practitioners, and second, an examination of the available knowledge of nurses and midwives’ completion of elements of the registration renewal standards, to determine if aspects of completion of these standards could inform this study.

The Search Process

A range of key discipline specific databases were used to locate relevant national and international research literature: Science Direct, SCOPUS, and ProQuest helped search multidisciplinary sources, and search engines; ERIC, Google Scholar were used to extend the field of the search. Additional relevant research papers were located from Digital Dissertations, and examining the references of relevant articles. The literature review search retrieved papers written in English.

The literature search took several paths to seek information about the registration renewal standards. The phrase, “recency of practice” used in the research database search engines retrieved no research studies. As this standard is used to demonstrate “competence” and “competency” these terms were helpful and retrieved many studies however, these were linked to CPD which formed another aspect of the search: continuing professional
development (CPD) (discussed next). Other terms connected to the focus of this investigation were used “regulation”, “registration”, “registration renewal”, “re-registration” in an attempt to locate papers that reported on proving competence through recency of practice in regards to registration renewal. However, the results then included papers on developments of registration processes in developing countries. Therefore, the findings were reduced to studies from countries that shared similar nursing and midwifery registration processes; Europe, New Zealand, Canada.

Numerous terms were used to search for post registration education synonymous with CPD. Terms including “self-directed learning”, “post-graduate education”, “Continuing Professional Education (CPE)”, “Continuing Education (CE)”, and “Life-Long Learning (LLL)”, were all used in the search of the literature to locate papers that presented research on aspects of CPD within the multidisciplinary databases.

A systematic approach was used to manage the diversity of the retrieved studies (Whittemore & Knafl, 2005). In this case, the relevance of research studies was assessed first by viewing the title and abstracts. Then, inclusion and exclusion criteria was used (Booth, Papaioannou, Sutton, 2012) to guide selection of studies that addressed the question, “What decisions are nurses and midwives making about CPD and RoP to meet the registration renewal standards?”

**Inclusion criteria.** Data was extracted from primary sources based on sample characteristics. Inclusion criteria helped select studies which specifically collected midwives’ perspectives on their engagement in completion activities known to meet registration renewal standards. Searching for profession specific details narrows the search to locate findings that provided comparative perspectives. The rationale for selecting discipline specific research studies, is supported by Booth et al. (2012) who warn that caution should be exercised when selecting literature to make like with like, comparisons. Too broad a field may present too much diversity (Booth et al., 2012). In this case study the search focused on retrieving literature with which to interpret the potential decision-making behaviour of midwives related to regulatory practices. Failure to consider the specificity of the midwifery professional role would have resulted in non-discipline specific findings. Organisational values and beliefs are influenced by the uniqueness of individual professions. To investigate the perspectives of other health professions in relation to registration practices would not lead to extending the purposive knowledge of how midwives behave in response to registration
renewal requirements. This may result in findings that fail to provide depth of detail from which to appreciate the characteristic behaviour of midwives. As a doctoral thesis this research sacrificed breadth of information for the necessity of specificity of detail (Bloomberg & Volpe, 2008).

Where there was a limited number of primary midwifery research studies, nursing research was used owing to the historical background of endorsed registration in Australia. Nursing offered a rich resource from which to study comparative elements of the registration renewal process because nursing and midwifery have a long history of interconnected regulation and a significant number of individuals working in Australia hold dual nursing/midwifery registration. Therefore, studies which examined nursing samples were sourced. The search was made specific for this investigation by limiting the search to include CPD activities of nurses and midwives. Subsequently, the search findings were limited by using the terms nurs* and/or midw* as prefixes.

The search terms were combined using Boolean terms AND/OR. These processes increased the specificity of the search. The majority of the studies located in this literature review search were found from nursing literature, however, one study located included nurse, occupational therapists and physiotherapists in the sample (Ryan 2003), and other studies included enrolled nurses and assistants in nursing (Wray, Aspland, Gibson, Stimpson, & Watson, 2008; Hegney, Tuckett, Parker & Robert, 2010) but not necessarily in a bid to meet registration requirements. Other studies included samples of advanced practice nurses or equivalents. However, studies of particular interest were registered nurses and midwives’ responses to CPD activities, perspectives, views, and attitudes related to the behaviour in relation to completion of CPD and maintaining competence linked to registration renewal.

Exclusion criteria. The results were reduced to the most applicable studies using exclusion criteria. All studies related to initial entry to practice training, re-entry to practice and outcomes of education program changes were discarded, as this study focused on post-registration CPD linked to registration renewal only.

The inclusion and exclusion criteria were used to reduce the results and highlight studies most applicable to the research issue being investigated. Thematic analysis was used to organise the literature, to identify consistencies, patterns and contradictions (Booth et al., 2012) in response to the posed objectives of the search.
Findings

The results presented from this literature review have been organised under two main headings:

1. Perspectives on registration renewal
2. CPD Influences and impact

Perspectives on registration renewal

As professionals nurses and midwives are regulated by standards of practice based on competencies (ANMC, 2006). Competence is an established necessity for registration renewal (Homer et al, 2007). As individuals, nurses and midwives are required to self-declare that they meet these competency standards at registration renewal (ANMC, 2009; NMBA, 2010). Contemporary knowledge of nurses’ and midwives’ perspectives when registration standards change is limited (Vernon et al, 2013; Katsikitis et al, 2013). However, what was evident in the literature was research knowledge on nurses’ behaviour when their registration status changes; specifically, when they have decided to gain an endorsement on the register for extended/advanced practice roles, such as to prescribe medications (Dury, Hall, Danan, Mondoux, Aguar, Barbieri-Figueiredo, Costa, & Debout, 2014; Weglicki, Reynolds, & Rivers 2015; Duff, Gardener, & Osbourne 2014; Canon-Diehl, Rugari, & Jones, 2012; Drey, Gould & Allan 2009). These findings will be reported in this section under two further subsections using headings: ‘Nurses and midwives’ perspectives on renewing registration when standards change’, and ‘Nurses’ and midwives’ perspectives of meeting the ordinary registration renewal requirements’

Nurses and midwives’ perspectives on renewing registration when standards change

Two recent publications have reported on nurses’ and midwives’ experiences of completing CPD for registration renewal after the introduction of statutory requirements. In Australia, Katsikitis et al, (2013) reported on practitioners’ responses to the changes in CPD, and in New Zealand Vernon et al, (2013) on nurses’ perspectives of changed registration standards in New Zealand. Other accounts of nurses’ and midwives’ experiences of engaging
in the registration renewal processes when regulations for registration renewal change are limited to historical studies that focused on the CPD needs of midwives during changes in registration processes in United Kingdom (Page, Cooney, Graham, & Holliday, 1996; Laslo & Strettle, 1996; Mitchell; 1997). Only one study by Vernon et al. (2013) specifically canvassed nurses’ perspectives of the changed registration renewal standards and thus is pertinent to this investigation.

In New Zealand, Vernon et al, (2013) completed research which investigated nurses’ understanding of the changed registration renewal standards, and how they demonstrated that they met the indictors of competence. Competence was measured through self-assessment of practice and professional development using the Nursing Council of New Zealand (NCNZ) Continuing Competence Framework (CCF), which requires nurses annually to demonstrate evidence of continued practice and professional development; a minimum of 60 days or 450 hours of practice within the last three years, and a minimum of 60 hours CPD in the last three years relevant to work environment (Vernon et al., 2013).

Electronic surveys were sent to 12% of nurses on the national register since 2005. A 43% response rate (n=1157) was received from a mix of Nursing Assistants (NA) Enrolled Nurses (EN) and Registered Nurses (RN), the majority of the survey population was made up of registered nurses (96%, n=1105). The views of nurses were collected to gather nurses’ satisfaction with the CCF and re-certification audit. Vernon et al., (2013) identified that the majority of nurses (76%) surveyed favoured 3 independent indicators of competence; self-assessment and declaration of competence, evidence of practice hours, and evidence of CPD.

Vernon’s study is helpful as it is a recent study reporting on the perspectives of nurses when registration renewal standards change, and how nurses perceived the regulatory changes in standards, on the New Zealand register. Hence, this study was useful as a potential comparison to the Australian situation as these three same independent indicators closely match the tenants of the Australian registration standards. However, these findings relate specifically to nurses. No midwives were represented by this study because in New Zealand midwifery is viewed as a separate profession to nursing. In Australia, the majority of midwifery registrants possess dual registrations.

Current understandings of CPD, and future CPD needs of nurses and midwives in Australia were investigated by Katsikitis et al. (2013) in relation to the changed conditions for registration renewal. The authors investigated the perspectives of dual registrant nurses and
midwives employed within one region of Queensland, Australia. Registered and Enrolled nurses and Registered midwives in one public and one private hospital completed a survey in which they were asked about their understanding of the change in CPD standard for registration renewal after the introduction of national standard requirements in 2010 (Katsikitis et al., 2013). From a response rate of 39% (n=289 responses) the results of this survey identified that this sample completed the requisite number of hours for registration renewal. The employees working full time (39%) indicated the highest level of annual CPD hours. Over 33% of participants’ identified that they engaged in 20-30 hours of CPD annually while 20% of participants indicated they engaged in an excess of 50 hours; well over the required hours. The sample of nurses and midwives in this study understood the new requirements, and met the 20 hours of CPD necessary for registration renewal with ease (Katsikitis et al., 2013). However, the research study did not collect data on how CPD impacted on their practice, nor how the participants intended to meet the RoP standard. Further research is necessary to address this gap in knowledge.

Prior to 2010 previous endorsements existed on nursing registers for advanced practice in Australian states. How individuals responded to the requirements to meet these conditions has been previously studied.

**Nurses’ and midwives’ perspectives of meeting additional registration requirements**

Practice roles where the practitioner practices outside or beyond the nurse or midwife normal scope of practice are defined in a number of countries; commonly practitioners with endorsements on the register are recognised as advanced practitioners (Dury et al., 2014; Weglicki et al., 2015; Duff et al., 2014; Canon-Diehl et al., 2012; Drey et al., 2009). Thus, an endorsement on the register acknowledges expertise and advanced practice. Research has focused particularly on how practitioners with advanced practice endorsement demonstrate competence to maintain the endorsement notation at annual registration renewal. This is normally in the form of additional CPD.

Studies related to maintaining competence as advanced practice practitioners were located in Australia, New Zealand and Europe (including the UK). In Europe, Dury et al. (2014) investigated the competencies, educational requirements and regulation of specialist nurses.
Using a cross-sectional online survey, 550 members of the European Federation of Nurse Educators and ten members of the European Specialist Nurses Organisation were surveyed. A total of 77 experts from 29 European countries responded to the survey. In addition to quantitative data, qualitative responses to open-ended questions were provided. The results of this study highlighted variations in titles, levels and length of education, certification and regulation requirements, and scope of practice for specialist nurses in Europe showing inconsistencies in the requirements to maintain endorsement across countries and highlighting a strong focus on clinical and technical aspects in the role of specialist nurses (Dury et al., 2014). Practitioners qualified to prescribe medications were among the majority of clinically extended roles identified. Dury et al. (2014) highlighted the professional requirements of registration renewal but did not provide details about the perspective of individuals in completing the standards. However other research has provided information about this (Weglicki et al., 2015; Drey et al., 2009).

In a recent UK study (Weglicki et al., 2015) semi-structured interviews and a focus group were undertaken with 16 advanced practitioners working in primary and secondary settings with the aim of ascertaining the aspirations, priorities and mode of CPD for non-medical prescribers. Four themes were presented from the findings; feelings of anxiety, which undermined practitioners’ confidence to prescribe; external barriers and other factors that exacerbated anxiety; a need for support; and a preference for face-to-face over online learning. The authors argued that the anxiety reported in the findings could stem from practitioners taking the pharmacology course because their employers required it, rather than from self-identified motives. Motivation for engagement in CPD is a common focus of research (Drey et al, 2009; Munro, 2008; Ryan, 203; Spencer, 2006), with preferences shown for undertaking CPD activities related directly to practice (Bahn, 2007; Danielson & Berntsson, 2007).

Practice in either a standard scope of practice or advanced practice role may influence engagement and preference for CPD (Drey et al. 2009). In an investigation to explore the relationship between undertaking CPD and commitment to the profession and their employer, Drey et al, (2009) used a survey to measure commitment to their employing organisational and profession. The survey used a validated measurement tool to collect data on role and CPD behaviour. CPD was categorised as mandatory, or self-selected professional development. The authors reported that 318 nurses (70%) had chosen CPD that was likely to
develop career opportunities over the previous 12 months, while 99 nurses (22%) had undertaken only mandatory update training in the same period, and 34 nurses (7.5%) had taken no CPD. Those in extended roles (89 out of 117) were more likely to have completed academic study for CPD in the previous year than nurses in standard roles (Drey et al., 2009). The significance of this finding is that it shows continuing CPD was considered important for demonstrating competence at an advanced level of registration and to progress career aspirations.

Simulation based CPD has become increasingly common and evaluations shed some light on CPD behaviours and motivations. Canon-Diehl et al. (2012) reported a study in which nurses in advanced roles as nurse anaesthetist assistants were asked to participate in high-fidelity simulation learning as part of their CPD and revalidation process. This study explored the usefulness of high-fidelity simulation as a tool for continuing education. 50 participants competed the evaluation. Nurses were asked to rank the scenario effectiveness in a survey; with 71% responding that they felt the simulation was highly effective as a learning tool and 81% identifying simulation was a valuable tool for assessing competence. However, only 59% favoured its use for recertification purposes, with the remaining sample unsure. The findings identified that nurses see value in the demonstration of competence through clinical scenario demonstrations, however the number who identified that they would like this to be used as a measurement for revalidation (endorsement for re-registration) was significantly less. The sample was small and purposive so the findings are not generalizable but indicate that further research is needed. One area of interest would be nurses’ and midwives’ perspectives of how they feel they should demonstrate competence for renewing endorsements.

Maintaining endorsements on the register requires additional demonstration of the advanced practice. The literature shows this is mainly in the form of CPD and direct clinical practice within the hospital setting providing patient care (Canon-Diehl et al, 2012; Weglicki et al, 2015; Drey et al, 2009). Advanced/extended practice roles requiring endorsement show a direct preference for practice specific activities as proof of competence. While these studies reported on the behaviour of nurses to complete advanced practice, no studies focused on midwifery as this is not considered as an advanced role, (and since 2010 is no longer seen as an endorsement/certificate on the nursing register). This deficit in knowledge identifies a gap in the research around midwives’ perspectives of demonstrating recency of practice for registration renewal. However, this restriction is limited to proving recency of
practice as other studies located in the literature review are informative and provide context of the behaviour of meeting one other element of registration renewal: CPD.

**CPD influences and impact**

If we look more broadly, the literature provided detailed knowledge of the influences on CPD selection and completion and impacts on practice. The findings from this literature review identified nurses and midwives’ behaviour, attitudes and preferences towards CPD, and enablers and disablers of completion of CPD. Most studies found reported on the completion of CPD by practising clinicians as part of their mandatory, statutory or in-service training, and motivation, and preferences for completion of CPD.

A range of formal and informal CPD activities were identified in this literature review: self-directed learning (O’Shea, 2003), didactic instruction, in-house/in-service sessions (Bahn, 2007), individual university courses (Ellis & Nolan, 2005; Gould, Drey, & Berridge, 2007), and professional programmes (Smith, 2009; Ireland, Bryers, Van Tei Jlingen, Hundley, Farmer, Harris, Tucker, Kiger, & Caldow, 2007) academic study (Ellis & Nolan 2005; Bahn, 2007; Spencer, 2006; Chui, 2005), and clinical skills development (Hind, Beresford, Kimm, Jokinen, Davis, & Bamford, 2001; Bahn, 2007; Ireland et al., 2007; Williamson, Mullet, Bunting, & Eason, 2005), and CPD that requires reflection on the relevance of the CPD to their clinical practice (Smith, 2009; Ellis & Nolan 2005).

Many studies shared similar research aims: to investigate the reasons for nurses’ participation in CPD (Drey, Gould & Allan, 2009; Joyce & Cowan, 2007; Ryan, 2003; Gould et al., 2007), and the issues nurses experienced in undertaking CPD (Pool, Poel, & Cate, 2013; Munro, 2008; Wray et al., 2008; Weglicki, 2015; Drey et al., 2009; Hegney et al., 2010; Tame, 2011; Katiski et al., 2013; Bahn, 2007).

Educational engagement has been shown to benefit individuals, the profession, service provision and ultimately patient care (Ellis & Nolan, 2005; O’Shea, 2003) and is established as a measure of competence for proving suitability to renew registration on an annual basis.

In addition, a myriad of research studies has focused on the enablers and barriers to participation, reported on the different types of CPD that nurses and midwives engage in, and their preferences for CPD. Furthermore, studies have attempted to examine the impact of CPD on practice. These focus areas are discussed here under three subheadings: (1)
Enablers and barriers (2) Nurses’ and midwives’ perspectives, and preferences around selection and completion of CPD, and (3) the impact of CPD on professional practice.

**Enablers and barriers to completing CPD**

The main barriers to completion of CPD are known to be issues with competing time challenges, and issues with financial funding faced by practitioners. Research from Australia, the United Kingdom and Sweden illuminates multiple factors found to influence practitioners’ access to, and engagement in, CPD activities. A range of factors have been reported as barriers to the completion of CPD. These include; competing time factors (Govranos & Newton, 2014; Katsikitis, McAllister, Sharman, Raith, Faithful-Byrne, & Priaulx, 2013; Barnes et al, 2013; Spencer, 2006; Gould, et al., 2007; Ellis & Nolan, 2005; Grisciti & Jacono, 2006) financial challenges (Munro, 2008; Gould et al., 2007; Ellis & Nolan, 2005); age (Katsikitis et al., 2013; Wray, et al., 2008; Gould et al., 2007); lack of opportunities (Wray et al., 2008; Ellis & Nolan, 2005); lack of confidence in their ability to study at tertiary level (Hegney, Tuckett, Parker & Robert, 2010; Brooks and Scott, 2006; Spencer, 2006; Ellis & Nolan, 2005) or to practise at an advanced level (Weglicki et al., 2015). Researchers have concluded that where practitioners may be hesitant to engage in CPD they may defer their education, with a consequent impact on compliance with professional regulatory standards (Munro, 2008; Gould et al., 2007; Ellis & Nolan, 2005).

Time was the main challenge identified in the completion of CPD. Time challenges caused by short staffing and busy ward schedules take priority over completion of CPD (Govranos & Newton, 2014; Barnes et al, 2013; Gould et al., 2007; Munro, 2008). In addition to lack of time at work, competing life commitments outside work also affect the time available for practitioners to undertake CPD.

An English study explored nurses’ experiences of CPD and examined factors that encouraged or discouraged CPD uptake (Gould et al., 2007). Data was collected from a random 10% of the nursing workforce in three London acute-care hospitals. Using the payroll system, surveys were distributed to investigate which CPD activities participants had accessed during the previous 12 months. A total of 451 useable responses were received containing 125 free comments. The majority of comments were positive about the completion of CPD, however, nurses felt that CPD should occur within work time and stressed the importance of relevant CPD content. Participants reported that pressure to
complete CPD put demands on their time, affecting home commitments, and ability to complete their studies.

Financial assistance to support CPD activity is provided to many nurses and midwives covered in public sector awards in Australia and the United Kingdom. Funding takes a number of forms including paid time for self-selected activities or as in one example, in Queensland, Australia, via a wage allowance inscribed in an industrial award (QLD Industrial Relations Commission, 2012).

In Queensland, the views of practitioners have been collected in three studies that used professional organisations to source responses. In the first study Hegney et al. (2010) used the Queensland Nurses Union (QNU), to investigate its members’ opinions about their nursing or midwifery registration practices (Hegney, et al., 2010). In a survey initially deployed in 2004, and then redeployed in 2007, QNU members were asked about their access to CPD. The researchers sent surveys to 3,000 of the 30,000 members of the QNU. The sample population included Assistants In Nursing (AIN), ENs and registered nurses (RNs), including midwives. Response rates of 44.9% in 2004 and 39.7% in 2007 were achieved; 85% of respondents reported that they had access to CPD education, and financial support from employers. However, the financial assistance from employer funding decreased between the two surveys and was identified as a barrier to taking CPD. In addition to the identified time challenges, financial challenges have been an ongoing common funding issue identified in Australia and England (Hegney et al. 2010; Munro, 2008; Gould, Drey, & Berridge, 2007; Ellis & Nolan, 2005). Some QNU members acknowledged that their CPD allowance was not always used for CPD, and often spent as part of their income (Hegney et al., 2010). The study did not investigate the value of CPD to practice or registration renewal.

A secondary analysis of the data focussed on the relationships between geographical location, the working lives of nurses and CPD completion (Henwood, Eley, Parker, Tuckett & Hegney et al., 2009). Researchers reported statistical differences in the working lives of nurses employed in different locations. They found distance and time spent travelling to CPD, to be major barriers to accessing CPD. They reported that nurses and midwives in outer regional, remote or very remote areas were more likely to be fully or partially supported by their employer for travel and funding for conferences and courses.

A third study was found which examined clinical supervision and CPD activities of nurses and midwives in Queensland (Barnes, White, Winstanley & Reed, 2013). Using an
online survey of Queensland Nursing Council (QNC) members. The researchers found midwives were able to access CPD opportunities, and received financial funding to assist in its completion of CPD. However, like other studies, Barnes et al., (2013) found barriers to the completion of CPD were lack of time, lack of ‘backfill’ and limited support. Consequently, the majority of respondents reported they would be interested in support from clinical supervision if it was offered to them in the workplace (Barnes et al, 2013).

Further afield time and financial funding have been found to influence CPD. In England Munro (2008) found that participants felt that their employer should fund CPD for the good of the service, while employers held the opinion and expectation that nurses should contribute to their professional development by donating their own time and/or money to fund the completion of their statutory required CPD. This phenomenon was referred to as the “charity paradigm” by Munro (2008). Munro recommended further research is needed into what motivates some learners to invest in their own self-development. Joyce and Cowman’s findings from a survey of Irish nurses undertaking a university program found that 76% of respondents had their study paid for by their employer, while 17% were self-funded.

Age has also reported as a factor in the distribution of CPD funding. A study reported by Wray et al. (2008) surveyed 2,610 UK Trusts and Primary Care Trust staff aimed at investigating the employment experiences of older nurses and midwives within the National Health Service (NHS), and investigated their behaviour in relation to CPD activity. A total of 510 surveys were returned (20% response rate) comprising 70% nurses and 9.4% midwives. Significant associations between CPD funding allocation and access with being a midwife and being over 50 years old were reported (Wray et al., 2008). Wray et al. (2008) suggested that age was also found to influence the ways in which practitioners chose to engage in CPD activities. For example, age was found to be a factor in determining the types of CPD engagement selected. Less CPD activity was found in nurses and midwives over 50 than those under 50 years. The findings of the Wray et al. study should be viewed with caution due to the small response rate, however what this study does add is a perspective on factors which may influence and motivate CPD selection and completion and suggests some differences based on discipline, nursing or midwifery.

Several challenges appear to exist universally which affect practitioners’ ability to complete CPD. Primary challenges are time and funding. How these and other influences may
impact practitioners as they determine their needs in relation to one or two registers in the changed environment in Australia from 2010 was of interest to the present study.

**Nurses’ and midwives’ preferences and motivations concerning CPD**

This literature review discovered CPD is completed for many different reasons. Studies originating from Australia, United Kingdom and Sweden have looked at the reasons why individuals participate in CPD; promotion, self-development, and mandatory requirements. Self-directed learning has been identified as an appropriate activity for nurses in accessing CPD possibilities (O’Shea, 2003). O’Shea (2003) suggests that adults benefit from self-directed learning, as this enables them to identify the material that is of interest to their learning needs. CPD selection is dependent on the period of a person’s career; with some experienced staff desiring CPD for promotion (Gould et al., 2007).

Increasing professional knowledge has been identified as a prime motivator in CPD (Danielson & Berntsson, 2007; Joyve & Cowan, 2007), with preference shown for selection of CPD activities linked directly to patient care (Bahn, 2007; Page et al., 1993; Ellis & Nolan, 2005). Ryan (2003) reported findings from a survey of 182 respondents across the disciplines of nursing, occupational therapy and physiotherapy in the UK and identified motivation for CPD stems from a need to update existing qualifications, increase the status of the profession as a whole, and demonstrate that an individual is professionally competent.

In Sweden, two studies (Danielson & Berntsson, 2007; Bahn, 2007) explored reasons why registered nurses take part in formal and informal learning and higher education and the extent to which their various learning experiences met their expectations. Danielson and Berntsson’s (2007) reported on the preferences that guided CPD selection of registered nurses within the first three years after initial registration. Results from this quantitative study based on 327 questionnaires showed a high proportion of the nurses had already engaged in further CPD education. Danielson and Berntsson (2007) found that value judgements influenced selection and completion of CPD. Preferences were applied to different types of knowledge; for example, the nurses in their study said that social sciences learnt during initial training held little significance for them once in clinical nursing practice. Consequently, they reported that they considered knowledge directly applicable to practice, as the most valued and meaningful outcome of CPD (Danielson and Berntsson, 2007). This finding is echoed by Bahn (2007). As with many studies the type of CPD and reasons for
selections was the focus, rather than the impact or connection to registration renewal or practice standards demonstration.

In Australia and focused on midwifery CPD, a specific program, The Midwifery Practice Review (MPR), has been reviewed by Smith, Brodie and Homer (2012). In interviews with 12 midwives working full time in midwifery-led models of care Smith et al,(2012) report midwives’ apprehension and anxiety over engaging in a CPD activity process in which they were required to create a professional portfolio, in which they reflected on their practice, and professional development needs. The reflective tasks were seen as highly academic activities and participants in Smith et al.’s study said they found the build-up to the submission of their portfolio and the interview stressful (Smith et al, 2009). The participants viewed the MPR process as an examination of their practice and saw the interview as an assessment aimed at observing for poor practice, rather than as a supportive activity. It appears from Smiths et al., (2009) study that a program designed with the intent of fostering professional development through reflective practice was perceived to have taken on a regulatory agenda. The participants valued the MPR portfolio as a representation of many years of accumulated hard work and experience and in that regard a validation tool. This was the only Australian study that reported on midwives as a specific group in relation to completion of CPD. It identifies the benefits of reflective practice, an element of the present CPD registration renewal standard for nurses and midwives in Australia but did not address the use of this type of CPD to meet registration renewal standards as they existed at the time.

The culture of the workplace environment can influence an individual’s choice of which type of CPD activity to select (Bahn, 2007; Govranos & Newton, 2014). In Sweden, Bahn (2007) found a preference for CPD that related to clinical practice. In three focus group interviews performed with 25 registered nurses, randomly selected from the population (n=162) of those undertaking post-registration courses. Bahn found both positive and negative values related to practice and education. In Bahn’s (2007) study, “the participants seemed to recognise a need to maintain their nursing competence at a high level, to meet their employing organisations legitimate demands that staff be able to provide safe and effective health care” (p. 719). Participants perceived the most relevant knowledge to be directly related to their nursing practice, thus Bahn (2007) reported that nurses valued informal learning opportunities that arose from working directly with colleagues with more
clinical experience, above academic learning opportunities. In Bahn’s, (2007) study most participants were completing courses within the workplace to advance their practice skills, in areas such as venepuncture. Bahn highlighted that the participants “showed evidence of strong psychosocial drive to improve and deliver high quality client care” (p. 719). Other researchers agree that the nursing workforce shows a preference for “on the job learning”, which Gould et al (2007) felt had “the greatest impact on patient care and keeps staff interested” (p.606). Such preferences for clinically based CPD activities show how these participants interpreted how competence could/should be demonstrated. Competence is a defining measure against which practitioners are asked to confirm for registration renewal.

Motivation and preference in CPD may be influenced by career aspirations. In United Kingdom, Joyce and Cowman (2007) explored the reasons for nurses’ participation in post-registration education, and found that a major reason was to obtain promotion (99%), or enable them to extend their clinical role (98%). Thirty-seven respondents completed the open-text option in their survey to indicate that they felt there was pressure on them to undertake a degree if they were seeking promotion. The authors acknowledged that educational investment in the leaders of the future will contribute to improved patient care, as nurses who are satisfied with their careers will work for longer, contributing additional years of experience to the health service (Joyce & Cowman, 2007). In another study from the UK, Tame (2011) investigates attitudes associated with perioperative nurses’ CPE from the perspectives of nurses. Tame had an unexpected finding related to “secret study” where CPD was completed with the purpose of professional development. In a descriptive, qualitative study 23 perioperative nurses were interviewed about their recent experience of formal university-based study. All were female, with between 2.5 and 30 years nursing experience. Findings revealed that workplace cultures and attitudes were not pivotal in deciding whether to study, but attitudes affected nurses’ decisions about telling others of their CPD study. While only three nurses revealed they had “studied in silence”, Tame (2011) suggested that the prevalence of secret study may be greater, as some potential participants may have been studying in secret, afraid of having their cover blown. Reasons for secret study varied, but included silence in anticipation of failure, fear of reprisals from peers, or being exposed for pursuing professional development and possible promotion. No link was made to meeting registration renewal requirements.
In Victoria, Govranos and Newton (2014) reported on the perspectives of nurses and how they perceived continuing education (CE) since the change in legislation. Using a case-study approach, the researchers explored the values and perceptions of 23 ward-based nurses in a case study; four focus groups and six semi-structured individual interviews were conducted to investigate the nurses’ values and perceptions towards CPE and what factors impacted on their engagement in education. Generally, CPE was seen as important to practice, and a necessary requirement for appropriate patient care (Govranos & Newton, 2014). However, participants saw the clinical practice environment and learning activities as separate entities, reporting a dichotomy between the ward workload and CE, thus the clinical area was not seen as a place where learning could occur (Govranos & Newton, 2014). Instead the workplace was identified as a contextual factor that influenced the individual’s capacity to learn, as the cultural environment could influence the individual’s views.

Overall, participants in these studies were motivated to complete CPD for internal and external reasons that were not reported as purely to meet statutory registration purposes. The majority of the participants in these studies reported a preference for CPD activities linked directly to clinical practice. Nevertheless, a small number of participants who have returned to tertiary education acknowledged positive personal and professional growth, which they confirmed was an unexpected outcome (Bahn, 2007).

The evidence collected in this literature review identified the known attitudes of health practitioners in relation to completion of CPD. Different motivating factors influence choice of CPD activities, the evidence from this literature review mainly reported on nurses’ perspectives and suggests that motivating factors can determine the decisions practitioners make about choice of CPD. Research evidence suggests that nurses and midwives value the importance of CPD that provides hands on clinical practice development that is directly relevant to practice (Hind et al, 2001; Gould et al., 2007; Bahn, 2007; Ireland et al 2007, Williamson et al., 2005) and make decisions about CPD selection based on the type of CPD activity or motivation of promotion opportunities (Joyce and Cowman, 2007; Spencer,2006; Bahn, 2007; Tame, 2011). From their data, Bahn (2007) surmised that participants viewed positive experiences of learning, where there was direct application of learning to practise (Bahn, 2007) and that there is negativity towards academia. This was evident in comments such as: “having a degree does not make you a better nurse, it makes you a pen pusher” (Bahn, 2007, p.721). In this literature review academic courses and study days were often
criticised because the content was not related sufficiently to practice; respondents in Gould et al’s study said that they thought nursing had “lost its way by becoming overly academic” (p.606) as lengthy written assignments were not appreciated based on the time required to complete them - this was perceived to encroach on life outside work. Similarly, the MPR process used practice examples to convey competence however the value of the reflective writing was only considered in retrospect (Smith, 2009).

Tame (2011), Bahn, (2007) and Govranos and Newton (2014) suggest the workplace culture also influences the choice of CPD. Thus some key finding from this literature review are that time constraints and financial barriers are real problems faced by nurses. Thus impacting on the completion of CPD, and potentially affecting the quality of care delivery. Thus, many authors in this literature review conclude that further research is needed to explore the impact of CPD on service delivery and client care outcomes (Spencer, 2006; Ryan, 2003).

The impact of CPD on professional practice

Positive outcomes attributed to CPD activities, include increased confidence, choice, autonomy, assertiveness, critical thinking, motivation and skills for lifelong learning (Duff et al, 2014; Spencer, 2006; Ellis & Nolan, 2005; Veermah, 2004; O’Shea, 2003). Continuing education (CE) is revered as the measure upon which professional competence is measured to show that theoretical knowledge gained through CE is applied in practice.

Duff et al, (2014); Gould, Drey, & Berridge (2007); Griscito & Jacono, (2006); Bahn (2007) and, Ellis and Nolan (2005) proposed that ideally CPE should be associated with improvements in patient care. Gould, Drey, & Berridge, (2007) reported CPD was viewed by nurses as vitally important for patient care, and participants called for, “a return to traditional values when much greater importance was placed on clinical experiences” (Gould et al, 2007, p.606). Griscito and Jacono (2006) argued that more participation is required by practitioners to engage in identifying their own learning needs, and Ireland et al. (2007) argued that maternity care providers in rural areas need specific skills and competencies and thus sustainable skills, competencies and CPD necessary for rural maternity care. Thus, Griscito and Jacono (2006) were critical of the lack of follow-up evaluations after individual courses, and felt more research is needed to examine nurses’ engagement in pursuing CPD.
Nurses in Spencers’ study of a small sample of nurses which investigated factors which motivated further education (2006) found that participants valued hands-on practice and client contact, but felt their ability to effect change was determined by their position held in the organisational hierarchy (Spencer, 2006). Therefore, personal motivation expressed through motivation to do further education for promotional reasons, academic stimulation, and wanting to stay ahead in order to be able support junior staff and students were key determinants in selecting CPD activity.

Teaching and learning approaches have been found to be significant in influencing impact and application to practice (Duff et al, 2014; Ellis & Nolan, 2005). Duff et al. (2014) evaluated the impact of a multimodal clinical learning approach on the adoption of Respiratory Skills Update (ReSKU) skills. This education process, used contemporary education practices of face-to-face and online learning. Duff et al (2014) used a sample of 90 Registered Nurses (RNs) to conduct a pre and post-test evaluation, on a non-equivalent control group. Statistically significant differences were found between the groups in relation to the application of respiratory assessment skills three months after the ReSKU course attendance. The authors concluded that the construct of clinical thinking in the clinical setting, combined with clinical reasoning and purposeful reflection, was a powerful educational strategy to enhance competency and capability in clinicians’ practice. Thus, research studies have confirmed educational approaches have been found to determine the impact on practitioners’ application of CPD to practice.

Ellis and Nolan (2005) in the UK aimed to identify those factors which appear to influence the outcomes of CPE. Their longitudinal case study followed nurses attending one specific postgraduate national nursing program in the UK, over time, to examine the determinants of positive outcomes. They examined the decisions making processes involved in the selection of CPE before, during, immediately after the program of study, at 6, and 12 months later. Using in-depth, semi-structured qualitative interviews with educators, nurses on the program, and their managers. Findings revealed that a complex set of factors affected the outcome of CPE, including the way in which CPE is selected, the nature of the educational experience, disposition towards the course, and the “practice milieu” in which staff work after the CPE. They found that selection of courses, is often random, with most participants taking what is available in the way of CPD activity to meet statutory requirements to complete CPD hours; rather than selecting based on self-identified learning needs. Concerns
were expressed around completing the course content and assessments were an issue, with participants expressing doubts about their academic ability, and competing demands of home, work and study. These concerns were not acknowledged by managers or educators during the course and nurses reported they felt unsupported with these competing issues.

In Ellis and Nolan’s study (2005) participants agreed that CPD was vitally important for improving patient care and valuable for career and personal development. Nurses who declared that they had benefited from the course appeared to be nurses who had been enthusiastic about the course in the first place. Nurses who identify their learning needs based on self-reflection and select CPD activities based on their own preferences are found to be motivated to complete the course, resulting in long-term outcomes in the clinical area as they began to question taken-for-granted practices.

**Summary**

This literature review found that there is much evidence surrounding the motivations, preferences and selection of CPD as well as enablers and barriers among nursing and midwifery research samples. The majority of studies reported on mixed or nursing samples. While the literature review identified motivating factors for CPD and preferences for CPD activities, motivations and decision making among midwives concerning RoP standards are not articulated.

There is limited research that has specifically focused on the decision-making behaviour of nurses and midwives in relation to meeting registration renewal standards. Reports on the perspectives of individual nurses completing registration renewal exists in only one study from New Zealand (Vernon, et al, 2013). What we know about registration renewal behaviour and practitioners’ perspectives is limited to how practitioners complete one element of registration renewal, CPD, and meeting the requirements of advanced practice endorsements.

In the current Australian context, the statutory RoP standards introduced in 2010, as a process of defining proof of competence has received minimal examination. Further, the introduction of a separate register for midwives and an option for endorsement on the midwifery register are new options for midwives when renewing their registration. Consequently, since 2010 midwives have been faced with additional decisions about
renewing one or both of their registrations; as well as meeting the standards for CPD and RoP separately for each register. Again this significant change has not received systematic inquiry and evaluation.

Therefore, research is needed to explore individual, and group perspectives on registration renewal requirements; particularly what influences impact on the decisions that are made by practitioners about meeting the national registration renewal standards. Understanding the impact on practitioners of the national registration scheme, creation of separate nursing and midwifery registers and the attendant registration requirements for each register is important for midwifery practitioners, the discipline and provision of maternity services, health service employers and registration bodies. This study will contribute to our understanding of influences and impact of this changed environment. It aimed to collect data in order to understand midwives’ responses to the change in the national registration environment in Australia and to examine the decision making processes related to meeting the registration renewal standards; particularly, how the change to national registration and the introduction of statutory registration renewal standards was received by members of the midwifery profession as they met the standards for CPD and RoP for each register.

**The Research Questions**

The study was informed by the following research questions:

- How are midwives negotiating the tensions between opportunities and challenges that the current requirements present them with?
- How are midwives engaging in continuing professional development?
- What decisions are midwives making about continuing to work in midwifery or nursing services given the current registration renewal requirements?
Chapter 3

Research Approach and Methods

This chapter outlines the approach to the research study and the methods used to conduct it. The purpose of this research study was to address the question, “How are midwives responding to the changed conditions for renewal of registration to practice in Australia?” In particular, the study investigates the meaning schemas (Kvale, 1996, 2007; Hughes & Sharrock, 1997; Crotty, 1998, 2003) constructed by midwives as they have engaged in meeting the continuing professional development (CPD) and the recency of practice (RoP) standard in this unique Australian context. Standardised competence declarations for all health practitioners (Health Practitioner Regulation National Law Act, 2009) constituted a potentially “disorientating” event for midwives. As a population, the majority of the midwifery profession had been familiar with registration as a nurse, with an endorsement to practise as a midwife in most jurisdictions in Australia, before national registration.

The change to national registration introduced a separate register for midwives with a new option of an endorsement for eligibility status and standardised registration renewal requirements (CPD and RoP). Together these present a possible catalyst for changing both midwives’ and nurses’ perspectives on their registration, roles and practice.

A longitudinal investigation was undertaken over two registration renewal cycles using an interpretive research approach based on social constructionism in order to explore and understand rather than explain or predict the consequences (Hughes & Sharrock, 1997) of the change. The shared perception and reported actions and behaviours of the participants in this study had the potential to reveal how they constructed meaning, but also to identify how their perspectives could change as a collective.

Social Constructionism

Social constructionism is the epistemological view that humans construct meaning from life experiences, forming “meaningful reality” from interaction with others. Crotty explains that reality is a socially constructed situation (1998). Individual perspectives are formed and influenced by personal life experience, and meaning making is impacted by
sociological background and cultural history. Consequently, the multiple constructs of socially bound existence, such as different social, cultural and political beliefs and value systems influenced by family, education, religion and socio-economic circumstances (Crotty, 1998, 2003) affect an individual’s interpretation of an event. Stake (2008) argues that where researchers are not present “to experience the activity for themselves they have to ask those who did experience it” (p. 134). As a result, the data retrieved from participants is subjective, based on a collection of descriptions, opinions, interpretations and feelings (Stake, 2008). Interpretivist positions are founded on the theoretical belief that reality is socially constructed and fluid (Angen, 2000). Social constructionism does not deny the existence of object reality, but argues that it is humans that socially construct the meaning of that reality based on their own perspective, and influenced by their culture, which provides the lens through which we view events (Crotty, 1998). Thus, validity or truth cannot be grounded in a single or objective reality, Angen (2000), Crotty (1998, 2003) and Stake (2008) agree that multiple versions of reality exist, research can collect versions of reality particular to the individuals being examined.

Socialisation develops awareness of the social world, and endows everyone with their own sense of meaning. Social realities exist, but an individual’s perspectives are constantly revised based on the environmental milieu and the social group. Socialisation of adults into professional occupations with exposure to different groups of people has been examined by many studies that have reported how socialisation leads to the adoption of shared meanings (Apker & Eggly, 2004; Birnbaum & Somers, 1989; Evetts, 2003). Initial professional education leads to the development of professional attributes and the creation of professional identity by instilling values and beliefs through the educational process (Apker & Eggly, 2004). As individuals’ experience professional training such as initial nurse education training they develop not only new knowledge and skills competencies, but also the new philosophical perspectives of each profession (Volti, 2011; Evetts, 2003; Birnbaum & Somers, 1989).

Adoption of qualities of occupational roles are the product of formal and informal socialising processes (Volti, 2011) and include expected characteristic values and beliefs in relation to professional behaviour. Volti (2011) identified professional behaviour to include language, demeanour, dress, and occupational work practices. Therefore, it is assumed by this study that professional behaviour would also involve values and meanings related to professional regulations such as maintaining registration, and the value of CPD. Practitioner
guidance frameworks such as the AHPRA registration renewal standards, the NMBA definition of practice, and the definition of a midwife (ACM and ICM) all act as professional frames of reference that direct practice at a macro level. They also have the potential to influence the way participants construct their responses to the changed registration renewal standards, at the meso level - referring to employment issues, and at a micro level - referring to personal values, beliefs and related issues.

Crotty identifies that ‘it is possible to interpret the same reality in different ways, and so strikingly diverse understandings can be found of the same phenomenon’ (1998, p.47). Consequently, the social nature of professional groups such as midwives means that there is the potential to gather rich data from the narratives from different individuals and also from conversations between groups of midwives as they make sense of change. The way meaning is constructed has the potential to be different depending on the type of role the midwife/midwives hold; for example, an educator or academic is anticipated to hold different meaning schemes about CPD compared to a clinician working directly with the public, whose priority is meeting the needs of their clientele. Therefore, in an attempt to understand or explain their experiences, adults apply meaning and values but constructionism appreciates that “multiple and even conflicting versions of the same event or object can be true at the same time” (Rubin and Rubin, 2005, p.27). Thus, social constructionism is a suitable approach to take when examining this research problem, where for the first time practitioners are being asked to renew their registrations for nursing and midwifery on separate registers. This approach facilitates the apprehension of meanings that develop for individual and groups as practitioners interpret the phenomenon and their situation.

Case Study

Case Study research can be used to answer interpretive questions, particularly for the study of a contemporary phenomenon such as the one under investigation. Case study can be undertaken to explore in order to better understand a particular event, where the case is of interest, and where “the stories of those living the experience are teased out” (Stake, 2008, p.122). Yin, a leader in case study methodology highlights the explanatory possibilities of the approach. He says, “the advantage of case study design is the ability to be able to explain causal links between real life interventions that are too complex for the survey or experimental strategies” (Yin, 2009, p.19).
Choosing the type of case study

Different types of case study have been identified in the literature (Stake, 2008; Yin, 2009). Stake (2008) classifies case studies as single cases of intrinsic or instrumental interest, or multiple/collective instrumental case. He identifies that an intrinsic case study is useful for “teasing out” details to better understand the particulars of the case in question. The focus is on collecting the story of those living the experience. He writes that the particular case does not necessarily have to be unique; the investigation does not need to seek to build a theory from the findings. Instead, the case can present an intrinsic interest. An instrumental case study is described by Stake as a case study that is “examined mainly to provide insight into an issue or to redraw a generalization. The case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else. The case still is looked at in depth, its context scrutinized and its ordinary activities detailed, but all because this helps us pursue the external interest” (p. 123). Instrumental case studies provide insight into an issue, so investigation seeks to understand it better, to appreciate the bigger picture, the phenomenon, from the participant’s perspective.

Yin (2009) distinguishes three types of case study on the basis of the purpose of the research: descriptive case study (to describe the phenomenon) explanatory case study (to explain), and exploratory case study (to illustrate). Yin (2009) also distinguishes between single, holistic or embedded designs, and multiple holistic or embedded designs. The current research represented an exploratory case study with embedded multiple cases (Yin, 2009).

The single event under investigation is the changed conditions for registration renewal. The unique phenomenon of the inaugural introduction of a national registration scheme was my main focus of interest; my aim was to tell the story of midwives’ experiences in the changed environment, identifying how they responded to the national registration renewal process, and the introduction of a separate register for midwives. The case study seeks to study any collective consensus formed by the cultural group of midwifery practitioners. However, it was important in this case study to not only include the midwives as part of the phenomenon, but to make them the focus of the investigation.

Stake advocates that the joint study of multiple cases is preferable, because he believes that understanding the larger population will lead to better theorizing (Stake, 2008). According to Stake’s (2008) model, each and every midwifery participant within this
investigation represented an instrumental case in themselves however typical or atypical they were in representing the diversity of the midwifery population. Therefore, the multiple embedded design (Yin, 2009) facilitated a focus on the points of interest; the midwifery practitioners. As the points of interest, and the sources of information each midwife became a unit of analysis. This case study sought to advance the understanding of their issues through exploring each midwife’s experience, and so the investigation was interested in the particular, but also the collective responses of the participants, which have the potential to illustrate the impact of the changes on the general population (Stake, 2008). Hence, this selected case study design with its embedded multiple case focus aimed to respect the individuality of perspective, while collecting the broader shared perspectives on meaning-making and values around registration for midwifery practice. Thus, the research questions focused on finding out how midwives responded to the changed registration renewal process.

**Defining the boundaries of the study**

The research design of this study was developed taking into account the different perspective of Yin (2009) and Stake (2005) on case study design. Yin (2009) argues that case study methodology is useful when boundaries between the phenomenon and context are not clearly evident, and where complex situations can be studied in context, so as to take into account the construction of various realities of different participants. However, Stake’s (2005) position contrasts with Yin, as Stake identified that a case is normally a specific unit of investigation that is well bounded. Thus, Stake (2008) advised that the issue topic, foreshadowed problem and issue under development and assertions should be stated to define the boundaries of the research questions and direction of the investigation. In the case of this research study, a structured approach is taken. The topic issue, problem under investigation, issue under development, and assertions are specified here:

**The topic issue** was the changed context in which professional registration renewal takes place. The changed registration renewal process caused by new legislation led to the introduction of the national Australian Health Practitioner Regulatory Agency (AHPRA) and the move of health professional regulation from state and territory based, to one unified national registration agency.
The problem under investigation – This inaugural event caused a changed environment that created a new phenomenon to investigate as for the first time nurses and midwives have to register with a national regulatory body.

The issue under development – How will midwives respond to the changes in the registration renewal process?

Assertions – As a population, the majority of the midwifery practitioners were familiar with registration as a nurse, with midwifery as a secondary certificate or endorsement. The changed registration renewal process required them to declare competence to renew their registration for two separate registers. This involved confirming that they met a number of registration renewal standards for each register; of interest to this study were the CPD and RoP standards. Furthermore, new opportunities present themselves with the first national registration process that has the potential to cause midwives to make decisions about their registration type and role.

This case study research used a longitudinal design to follow the participants over two registration renewal cycles. The phases of the study are explained further in the methods section below. The purpose of the selection of the participants was to collect data from midwives in a wide range of roles and service types. It involved looking for what is typical and what is atypical between the cases, and to detect and study common occurrences (Stake, 2008). This purpose was consistent with the need to explore the changed conditions of registration renewal and study the midwives’ responses to these changed conditions, and generated a detailed portrait of this situation across two registration renewal cycles.

Critiques of the case study methodology

Case study research has been demonstrated to be a legitimate contemporary research methodology in nursing (Houghton, Casey, Shaw & Murphy, 2013; Houghton, Murphy, Shaw, & Casey, 2015; Casey & Houghton, 2010) health-care practice (Anthony & Jack, 2009), disease transition (Courtnay, Merriam & Reeves, 1998; Courtnay, Merriam, Reeves, Baumgartner, 2000), and education (Merriam & Caffarella, 1999). However, the methodological design of case study is not consistent, and lack of rigour has been seen as one of the key weaknesses in the reporting of qualitative case studies (Gilbert & Ruigrok, 2010; Anthony & Jack, 2009).

Gilbert and Ruigrok (2010) undertook a review of 10 papers published on management issues between 1995 and 2000 to provide evidence-based strategies for
ensuring rigour in case study. They explored three strategies for ensuring rigour: internal, construct and external validity (Gilbert & Ruigrok, 2010). Lack of rigour was seen as the main weakness of qualitative case study. Transparency in the reporting of the research was highlighted as the most effective way of producing a rigorous qualitative case study report, meaning that what actually occurred is reported (Gilbert & Ruigrok, 2010). They reported that the logic of reporting what actually happened during the planning, data collection, analysis and write-up was often hidden in terminology, or the research was reported as seamless and removed from the realities of real research (Gilbert & Ruigrok, 2010).

An earlier study by Anthony and Jack (2009) conducted an integrative review of 42 qualitative case studies published between 2005 and 2007 to critically analyse the contemporary use of case study methodology in nursing research. These researchers sought to examine where case study had been used, why and how it was used and then evaluated the rigour of published case study reports. Anthony and Jack (2009) reported that while high quality case studies have been conducted in nursing research, about a third of the research publications in their review did not adequately demonstrate the rigor of their study. They also commented that the authenticity of research comes from the credibility (truthfulness) of the findings and transferability of the outcomes (Anthony & Jack, 2009). Anthony and Jack (2009) concluded that quality is enhanced when well established theoretical guidelines are followed as theoretical frameworks illustrate and support credibility.

Houghton et al, (2015) reported that using a case study design facilitated flexibility and depth of detail in data collection. In a bid to illustrate the specific strategies that can be used to ensure the credibility, dependability, confirmability and transferability of a study, these authors used a multiple case study design in research that explored the role of the clinical skills laboratory in preparing students for nursing practice. Triangulation was facilitated by gathering evidence from multiple sources, and data was collected from semi-structured interviews, non-participant observations and documentary sources at five sites. The researchers verified that “it is important that the research is conducted in a rigorous manner and that this is demonstrated in the final research report” (Houghton et al., 2012, p. 12). Strategies identified by these researchers to improve credibility included “prolonged engagement and persistent observation, triangulation, peer debriefing, member checking, audit trail, reflexivity, and thick descriptions” (Houghton et al., 2012, p. 12). These studies suggest that in order for case study to illustrate the trustworthiness of the research
investigation, a clear chain of events has to be kept in field notes and should be available for audit purposes. Figure 1 on the following page illustrates the chain of within this study.
<table>
<thead>
<tr>
<th>Time Line</th>
<th>Phases</th>
<th>Activity</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2010</td>
<td>Ethical Approval</td>
<td>Creation of protocol for interviews</td>
<td>20 participants consented for individual interviews.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 midwives consented for focus group</td>
</tr>
<tr>
<td>Oct’ 2010 to 2013</td>
<td>Recruitment</td>
<td>Advertisement in ACM News, Conferences, Purposive sampling</td>
<td>Information sheets sent and times arranged for interviews, consent forms sent for reading before the interviews</td>
</tr>
<tr>
<td>Oct’ 2010 to June 2011</td>
<td>Phase 1</td>
<td>Initial interviews</td>
<td>Transcribed and analysed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Labels given to repetitive data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Categories identified</td>
</tr>
<tr>
<td>May 2011 to Nov’ 2014</td>
<td>Phase 2</td>
<td>Follow up interviews revisited identified labels /categories</td>
<td>Transcribed and analysed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>➢ Labels and categories confirmed or explored further</td>
</tr>
<tr>
<td>Oct’ 2010 to Feb’2014</td>
<td>Analysis</td>
<td>Amalgamation of constructed labels and categories into themes</td>
<td>Theme 1: Motivation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Relationships with women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Relationships with peers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Self-assessment ‘on par’</td>
</tr>
<tr>
<td>2013</td>
<td>Outputs</td>
<td>Abstract for ICM conference</td>
<td>Presented at ICM June 2014 conference</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paper 1 – ‘Nurse Education Today’ on Theme 1</td>
<td>Paper published online November 2013</td>
</tr>
<tr>
<td></td>
<td>Ongoing analysis</td>
<td>Reflection on analysis = Categories of practice</td>
<td>Paper 2: Publication in Australian Health Review</td>
</tr>
<tr>
<td>November 2013</td>
<td>Phase 2 continued</td>
<td>Focus Group Interview to test interpretation of analysis</td>
<td>Transcribed</td>
</tr>
<tr>
<td>Feb’ 2014</td>
<td>Online Augt, 2014</td>
<td>Deeper exploration moving up from the data</td>
<td>Themes x 3 Constructing professional categories in midwifery: Rotation, Restriction and Extension</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Publication in Woman and Birth. 2015</td>
</tr>
</tbody>
</table>

Figure 1

*Chain of events in research procedures*
Methods

This longitudinal study planned to collect data across two registration renewal cycles to study the responses of midwives as their registrations were automatically transferred from state and territory regulatory bodies to the AHPRA national registers by June 2010, without any requirement to declare compliance with the national registration renewal standards. The first time midwives would be required to register under the new requirements was by 1 June 2011. For this reason, the interviews in Phase 1 were planned for the year between transfer and the new initial registration process (July 2010 – May 2011). The Phase 2 data collection would occur in the following year (June 2011 – June 2012). Three focus groups were then planned to test emergent themes after analysis of the Phase II individual interviews. Interviews and other processes of this research study were operationalised once ethical approval for the study was granted.

Ethical Considerations

Ethical approval was applied for from the University of the Sunshine Coast Human Research Ethics Committee under negligible risk, as the nature of the data collection did not entail gathering personal or sensitive information. Documentation samples were submitted with the application: for example, invitations, information sheet, consent forms, and interview procedure containing an aide memoire. No adverse incidents were anticipated to occur; however, in the event that the participant revealed personal or professional issues or information, the plan was to refer them to an appropriate professional, such as their doctor, the professional body (ACM), or the Nursing and Midwifery Board of Australia.

Plans were made to protect the identity of participants. Pseudonyms were planned and provided to participants, and all names of workplace establishments de-identified. In the case of their objects revealing participants’ identity, such as photographs, a strategy to use a substitute image was planned. This was necessary where images would be used at conferences, posters, or other publications to protect anonymity of the individual. Further measures necessary to conduct ethical research meant that all interviews were digitally recorded, and then transcribed and stored on NVivo™ on a password-locked computer. Printed copies of the transcribed interviews from Phase I and II were stored together with images of objects in a locked filing cabinet, as per the conditions of the ethics approval (Appendix D).
The Research Sample

A purposive sample was needed for this study (Berg, 2004; Blaikie, 2000; Patton, 1990, 2002). Blaikie (2000) suggests that in a purposive sample participants are homogenous as they share an experience in common, in this case the changed registration renewal environment. The majority of midwives in Australia are dual registrants. The population of midwifery practitioners is diverse due to variations in the types of initial training programmes, different practice experiences, career trajectories, and subsequent CPD. Midwives from a range of states and territories, and diverse roles and work places, were sought to collect different perspectives on the changed registration renewal process.

Recruitment

A number of convenience strategies were planned to recruit the participants to this study. Following Morgan’s (2002) recommendation to target resources accessed by the desired participants, midwives were targeted through a national advertisement placed in the Australian College of Midwives (ACM) newsletter, and a state-wide advertisement was placed in the Queensland Nurses Union (QNU) newsletter. In addition, poster advertisements were placed at two national conferences attended by midwives, and invitations placed in conference bags.

Midwives who responded to the advertisement (Appendix E) or an invitation (Appendix F) were sent an information sheet (Appendix G) and consent form (Appendix H) and asked to identify if they wished to participate in the Phase I and Phase II individual interviews or a Phase II focus group interview. The information sheet outlined the commitment expected from participants in the research study, namely taking part in two interviews, with a request to bring along to the first interview an object of significance to them as a practitioner. Interested practitioners then made contact with the researcher via email or telephone to discuss any questions, and to organise an interview date, time and venue.

A sample size (n=20) was selected that was considered sufficient to generate a diverse group of midwives from different states and practice roles. Saturation of recurring data has been found to occur within 12 interviews (Guest, Bunce, & Johnson, 2006) and therefore a sample of 20 midwives was expected to result in no new themes.
Chapter 4 introduces participants and identifies the main role of participants, explaining practice type, context of their workplace, states of practice and dates of interviews. For the purposes of this case study, interviews were the primary source of information. Table 3 illustrates the data collection procedures; timing to collect data in registration renewal cycles, and the sources of data.

Table 3

*Illustration of Sources of Data Collection*

<table>
<thead>
<tr>
<th>Research Phase Dates</th>
<th>Process</th>
<th>Data Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1 Oct 2011 – May 2012</td>
<td>Initial Interview with each participant Objects included in interview to elicit information</td>
<td>Demographic information Interview Transcripts Objects Field notes</td>
</tr>
<tr>
<td>Phase 2 May 2012 – Jan 2013 Focus group – Oct 2013</td>
<td>Follow up interview with each participant Focus group with second sample of participants to confirm and discuss key themes</td>
<td>Interview transcripts Focus Group transcripts Field notes</td>
</tr>
</tbody>
</table>

**Approach to Data Collection**

**Individual interviews**

A conversational responsive interview approach was planned for Phases I and II individual and focus group interviews, as this approach permits interaction between the interviewee and the interviewer. Interviews provide privileged access to another individual and their experiences (Kvale, 2007). This type of approach has been described by writers as a conversation style interview (Kvale, 2007; Rubin and Rubin, 2005; Silverman 2013, Ellis and Berger, 2003). Ellis and Berger (2003) describe this approach as a “conversation-style interview”, while Rubin and Rubin (2005) call this style of interview “responsive interviewing”. In both cases, these writers explain that the researcher responds to the participants’ replies,
and introduces new questions based on their discussion, rather than using a script of pre-determined questions.

In today’s climate, one-to-one interviews can be carried out in a number of ways such as face-to-face, or via Skype or telephone. Language makes the transmission of thoughts and feelings possible by constructing concepts that relay the meaning of their experiences (Crotty, 2003), but body language also conveys much more data than can be gained by telephone alone, such as how someone is feeling or what they are doing while they are speaking.

The aim of the research conversation is to gather information and meaning perspectives (Kvale 2007), which is achieved by using open questions that enable the participant to take the conversation in their preferred direction. In Phase I, an interview procedure was employed using an aide memoire (Appendix I), which identifies opening questions used to initiate the conversation. Conversations are not neutral acts (Kvale, 2007), as the aim of the interview is predetermined by the researcher and outlined in the information provided in the participants’ information leaflet (Appendix G) before the interview.

Although the researcher has predetermined the focus of discussion, they should not dominate the conversation. Instead, the conversational space is shared, and the participant is enabled to share their experience through their own lens, to express the importance of their experiences through personal reflections. Thus, the researcher acts as a data collection tool, yielding greater details of specific issues as they arise, something that is not possible with predetermined structured questions. Nicholson (2003) writes that the relationship during the interview between the researcher and participant, and the mutually understood meanings created, become the data. This research attempts to construct such meanings around registration renewal, particularly the RoP and CPD standards. Therefore, the opening research question focused on asking individuals to describe how they responded to the registration renewal standards. It was expected that participants would discuss their behaviour and the decisions they made about renewing their registration for practice as both nurses and midwives.

**Using objects to elicit meaningful narratives**

The use of objects during research interviews encourages participants to share meaningful information during research conversations (Knowles and Sweetman, 2004; Becker,
2000; Yin, 2009; Bell 2002; Reavey and Brown, 2009). Qualitative researchers in the social sciences have used visual material as an integral part of the research process, as a means of generating data (Banks, 2007), or a means of assisting participants to express themselves. Becker argued that visual images are integral to our daily lives and to ignore their significance would reduce our understanding of the participants being studied (2000). Knowles and Sweetman (2004) and Becker (2000) identified that objects can assist an individual to portray meaning through expression of pride or collegiality, such as membership of the professional group.

Yin (2009) identified that objects, when relevant, can be an important component in the overall case, and so participants in this study were invited to bring any object that had significant meaning to them along to their Phase I interview to assist them with expressing values that they attributed to their practice, and in describing their experiences. The objects could be physical or non-physical. Physical objects have been described in the literature as buildings, rooms, memory files, message boards, manuals, computer memory, and magnetic tapes (Berlin & Carlstrom, 2010). Nonphysical objects include verbal expression and mental images, which have been described as non-physical artefacts that possess object-like characteristics (Berlin & Carlstrom, 2010). As a relatively new method of data collection, a standardised system of managing objects does not yet exist (Bell, 2002). Ethical and methodological issues arise when using visual research artefacts that could identify participants, such as photographic images or personal letters and cards (Bells, 2002). Objects have multiple representation, meaning and purpose within the research literature. For example, Atkinson (2004) argues that objects can be representative of a lived experience and reverberate beyond the personal, and into the collective cultural realm.

**The follow-up second interview**

Phase 2 data collection was planned to commence 6 to 12 months after the initial interview, depending on scheduling factors that involved ensuring the participants had undergone another registration renewal experience. The aim of completing the second interviews was to study the responses of the participants to the changed conditions over time, to investigate any change in their perspective on the registration renewal process. In Phase II, the second interview was conducted, with conversation focused on confirming categories constructed in Phase 1.
The second interview with each consenting participant was planned to assist in the exploration of changed opinions, values and behaviour between the first and second interview in relation to registration renewal. Ellis and Berger (2003) identified that human phenomena are always evolving, changing and developing. Hence, with a constructionist viewpoint, it was appreciated that the collected findings would never be finite or final, so this longitudinal study provided participants with an opportunity to reiterate or adjust their story in the subsequent interview in Phase 2, enabling respondents to reflect on, change or build upon their experience of change over time.

Phase 2 also involved the use of focus groups interview to test the developing themes created from analysis of Phase 1 and Phase 2 individual interviews; supplemented by field notes.

**The planned approach to the focus groups**

Focus group interviews were planned as a way of confirming the findings collected from the Phase I and Phase II individual interviews. The collection of focus group data was anticipated to add richness and depth to the already collected individual interview data. Traditionally, midwives are comfortable with talking together to reflect on birth and family events, as shown by Kirkham (1999) in her ethnographic studies on midwives. Madriz (2000) has also identified, how “group interviews are particularly suited for uncovering women’s daily experiences through collective stories that are filled with cultural symbols, words, signs, and ideological representations” (p. 839).

The planned approach to the focus group interviews involved gathering midwives from the same state or territory together to discuss the findings from the individual interviews. Statements and questions would be formed based on the findings from the data. Participants would be presented with the statements and asked to discuss their thoughts on the findings and add their perspectives. It was anticipated that focus group participants would either agree or disagree with the statements but then provide richness to the existing details.

The power dynamics of focus groups means there is always the possibility that the focus group interview could be plagued by issues. Some methodological issues with performing and analysing focus groups can arise due to the interactive nature of focus groups (Richards, 2013). Participants may not be talkative or, as Morgan (2002) and Smithson (2010) suggest a vocal member could dominant the group, causing the dilemma that the opinions of
one or two members may be over-represented. However, this was avoided by facilitating the opportunity for each group participant to have the opportunity to respond to the statements and questions. The events of the interviews (individual and group) were recorded as interview summaries and field notes.

**Field notes collected across both Phase 1 and Phase 2**

Field notes in this study took a number of forms: a diary of research activities, and a record of data collection activities in the form of a diary of chronological events. Yin (2009) advocated that the validity of findings is strengthened by using many sources of data, including field notes as they help to achieve the triangulation of evidence.

Field notes were started at the planning stage and continued throughout the research in the form of notes on the research design: for example, notes on the recruitment strategy, methodology, outcomes of meetings with supervisors, and progress of the investigation. Summary sheets were made for each individual case and included the demographic information and details of the object the individual used during the interviews.

**Research Procedure**

Data collection followed the planned research schedule as described, with one exception. Instead of three focus groups, only one focus group was performed as the findings from the one focus group was adequate in generating sufficient data with which to evaluate the findings from the individual interviews.

Ethical approval for negligible risk was granted on 22 September 2011 (S/11/360) with approval expiring on 1 December 2013 (Appendix D). Therefore, data collection was able to start soon after the initial transfer of registration from separate state and territory jurisdictions to one national register.

Twenty participants were recruited from four states for the individual case studies. Recruitment was assisted by two educators who attended a national conference and assisted in distributing invitations to a wider population of midwives who had not attended the conferences, a form of snowball recruitment (Patton, 2002). Five participants were recruited this way. All participants were provided with information sheets (Appendix G) and consent forms (Appendix H).
Phase 1 data collection started with the initial three interviews completed in the last week of October and first week of November 2011. Data collection then ceased to allow reflection on these initial interviews to determine if any changes were necessary to the conversation approach to the interviews. Phase I continued to collect data between January 2012 and May 2012. Phase II collected data 6-12 months later, so the initial three interviews took place in August 2012 and the remaining interviews were completed over the rest of the year. Interviews had been completed by January 2013. The focus group was completed in October 2013.

**Phase 1 Data Collection**

**The first interview.**

An in-depth conversational interview was conducted with each consenting midwife between October 2012 and September 2013. Twenty participants consented to take part in two interviews. Venues, dates and times were arranged to suit each individual participant. Interviews were conducted in convenient locations such as hotel rooms, conference venues, work places offices, and hospital staff rooms, and also over the telephone.

The majority of interviews were performed face to face with participants completing written consent forms prior to the first interview. Eight interviews were undertaken by phone. Skype was not an option selected by participants for the interviews. In the case of telephone interviews the information sheet and consent forms had been sent by email. Where these had not been signed and returned, verbal consent was achieved by reading the consent form to the participant prior to the first interview and gaining the participant’s verbal consent on the digital recording prior to beginning of the interview. Participants were informed that the information was confidential and any transcripts used in publications would be de-identified.

Each interview took approximately 60 minutes. The format of all interviews took the same approach. All interviews were digitally recorded. An aide memoire (Appendix I) was used to guide the interviews. To start the conversation, a statement outlining the regulatory changes was made, to which participants were asked to comment. Participants were invited to share their opinion of the opening statement, and to give their interpretation of the
changed registration renewal standards. Participants were asked how they would meet the statutory standards for CPD and RoP at the next point of registration renewal.

Prompts from the interview procedure contained in the aide memoire were used to stimulate further discussion (Appendix I). Each participant had an opportunity to lead the conversation in another direction of their own making, to explore their personal experiences, and to follow and record any change in their perspective, practice and meanings. This resulted in personally relevant discussion, but also discussion of the context of the profession and/or their workplace and colleagues.

The goal of the interviews was to rely as much as possible on each participant’s view of their situation, in order to study their meaning-making around their experiences (Rubin & Rubin 2005; Ellis & Berger 2003) and their objects. Further details and clarification was asked for where necessary, in order to improve the quality of the data, and facilitate collection of nuances of individual experiences (Kvale, 2007).

**Objects**

During the first interview, in Phase I, the participants were invited to explain the relevance of their object to add another dimension to the discussion, in the hope of extracting deeper meaning about personal values of practice. Atkinson (2004) highlights, objects can assist an individual to express meaning during the sharing of experiences. Physical objects selected by participants for discussion at the interview took the form of thank-you cards, photographs, gifts from women and keepsakes; non-physical objects included midwives’ memories of interactions with women, family/cultural values and the ACM philosophy.

The objects brought to the interview were explained by each participant. As the meanings and values were articulated through expressions of stories, experiences related to nursing and midwifery practice were illuminated from their chosen object. The participant’s stories about their objects became additional data that enhanced the meaning of the interview narratives; in some cases the discussion about the object provided new information in relation to their views about their practice, roles and registration renewal.

At the end of the interviews, participants were thanked for their engagement in the interview conversation and asked if they were happy to receive a transcript of their interviews via email to confirm the validity of the transcript. About half of the sample agreed to confirm
the accuracy of the transcript. All participants agreed to the follow-up interview and agreed to be contacted by email or mobile phone to organise a follow-up interview in 10-12 months’ time.

Field notes

Throughout this research study field notes were kept contemporaneously in structured and unstructured formats. Examples of the unstructured formats are two journals that were kept of personal reflection. The first form of field notes was a journal that diarised the chronological events of the research, and a second journal recorded reflective notes taken during the course of data collection. Field notes on data collection recorded reflections before, during and after interviews over the course of the study, and formed unstructured reflections on data.

Structured field notes were kept of each interview. Participants completed a pre-interview survey to record their age range, details about their initial and subsequent registration status, and practice experiences. This information was recorded in the form of demographics sheets. Intra-interview field notes recorded the location of the interview, the atmosphere and any points of interest during the interview, including observations of participants’ behaviour during the face to face interviews, such as their demeanour and responses to issues. Post-interview summary notes recorded the details of the venue, any interruptions during the conversations, emotional responses of the participants to the subject matter, the participants’ object, my immediate reflections on the interviews, and any participant comments that necessitated further exploratory investigation, such as referral to the online learning resource Mid Plus or professional guidance websites.

Field notes were written in the form of memos about thoughts on findings from literature reviews, hunches during analysis, and reflection on professional guidance documents published for the midwives to support them during their registration renewal process. Field notes were kept on documents that bore any significance to the change in registration that were collected and archived during the term of this research study. Professional practice documents such as professional publications (e.g. AHPRA and NMBA standards, guidance notes -Frequently Asked Questions and definitions), union news articles (e.g. QNU, ANMF), commentaries from professional organisations (e.g. WHO), photo shots of web blogs, journal articles on the phenomenon and website information were used as information against which to test findings. Thoughts and reflection generated by these
documents were recorded as field notes and memos, which were then used in the writing of this thesis.

Later field notes included analysis in the form of drawings, diagrams, flow charts and webbed mind maps that portrayed the “thinking up” from the data that ultimately led to the creation of abstract ideas, and ultimately interesting themes. Many of these musings led to the construction of tables that illustrate the findings.

**Procedure of Phase 2 Data Collection**

**Second interviews**

Initial findings from the first interviews were developed and presented as categories at the second interviews in Phase 2. Sixteen midwives of the original 20 participants recruited to the study were able to participate in the follow up interviews. Categories created from the first interviews included factors (relationships with peers, women and employers) that later were identified as motivating factors in the decisions midwives made about meeting the registration renewal standard. These categories constructed from the collective narratives of the sample helped to focus the direction of the second interviews. Midwives were invited to share their thoughts on the categories, this procedure enabled participants to provide constructive feedback as they were asked for confirmation or clarification of the initial analysis. The conversations from these second interviews generated further details and depth of understanding of their perspectives. This data was then used to direct the focus group interview that was also conducted in Phase II.

**The focus group interview**

The focus group participants were all midwives on both the nurse and midwife registers, working at the same public hospital at the time of the focus group. The recruitment strategy for group interview participants focused initially on targeting conferences attended by midwives, but in Phase II a strategic move was made to approach collegial contacts in states where there was no representation. The Australian Central Territory (Canberra), South Australia, Northern Territory, and Tasmania were targeted. The venue for the group interview was arranged in Tasmania in response to the location of the volunteers.
The focus group was held to test the credibility and trustworthiness of the emergent themes. Merriam (1998) acknowledged that researchers have to force themselves to make decisions to narrow their focus on what is pursued within focus groups. Thus, one statement and three questions were created based on the findings generated from the individual interviews, objects, field notes and documents; these are outlined in the Aide Memoire focus group procedure sheet (Appendix J). This statement and these questions assisted in gathering confirmatory information and facilitated critical reflection on categories that had been generated from the first and second individual interviews.

The group interview lasted for approximately one hour and was digitally recorded. As the researcher, I directed the discussion, requesting each participant to respond to the opening statement, facilitating free expression, and encouraging one quieter member of the group to speak up. Focus group participants were initially asked to share their experiences of meeting the changed conditions for registration renewal in terms of CPD and RoP requirements. This strategy aimed to provide participants with the opportunity to verbalise their views on this phenomenon. Participants were then asked to comment on categories created from the previous participants’ individual interviews. The questions used in the focus group are listed in the focus group procedure set out in Appendix (J). Two categories were tested. Focus group members confirmed the importance and value of relationships with women, peers and employers. The consensus within the focus group confirmed the construction of the category “motivating factors”, which was constructed from a variety of narratives that discussed the value of relationships. In Chapter 5 Publication 1 presents the findings published in Nurse Education Today (Gray, Rowe & Barnes, 2014).

The second category – an emergent dichotomy of perspectives around what nursing and midwifery practice entails – was also investigated by the group. This category produced controversy as the group members could not agree on the emergent theme thus far. The divergence identified within the group shared commonality with the findings from the individual interviews. Some individuals were adamant about the separateness of practice activities between nurses and midwives. Others insisted that midwifery is a sub-section of nursing and explained how RoP and CPD for nursing could be met within the practice of midwifery. While some participants disagreed, there were clearly defined camps of opinions. The views of participants were established and non-negotiable, and hence the dichotomy was entrenched in their philosophical perspective on nursing and midwifery.
The Analysis Process

Analysis of the research data commenced with the first interview and continued throughout data collection in Phase 1 and Phase 2. Figure 2 illustrates the data management processes during the early stages of phase 1 and 2, and depicts the steps taken from research data collection and manual coding to computer coding then back to manual coding for the final analysis. It illustrates a detailed breakdown of how each and every interview was managed and coded. Data included the narratives from the first and second interviews, including narratives about the participants’ objects in the first interview, and focus group data from Phase II. Additional data, such as demographic details and notes collected from pre-, intra- and post-interview summaries were included with field notes.
Order of Activities

Interview (plus summary sheet and field notes)

Listen to interview

Transcribe interview

Read and re-read transcription and make additions to summary sheet identifying specific points of interest

Read to identify poignant comments related to the research questions and comments of possible significance to the phenomenon

At 3 interviews. Began manual labelling process

At 12 interviews commenced use of NVIVO to categorise the responses. Created notes that defined each category

Once 20 interviews were completed the categories created were compared and analysed. Further refinement was made and a provisional response to the research questions was written.

Participants were sent their initial interview transcript and a follow up interview was arranged to confirm or dispute the preliminary labels and investigate any change in circumstances

Follow up interviews 16/20 completed and transcribed. Summary sheets created, vignettes written and the frequency of commonly shared categories. Further notes on categories written.

Figure 2:

*Process of data management during Phase 1 and 2*
Handling the data

A thematic approach was adopted to analyse the data and construct themes from the data collection strategy. Interviews were digitally recorded and then personally transcribed verbatim before being sent to participants in a consultation process to seek confirmation or clarification from the participants. Richards (2013) suggests that human interaction with the data is necessary to construct meaning as themes are like threads of ideas that are discovered through good enquiry. Repeatedly listening and reading and re-reading the transcripts enabled me to be immersed in the participants’ stories. This enabled me to gain familiarity with the data and absorb the participants’ meanings, and identify early labels for the recurrent items constructed by the participants.

Data analysis occurred in a combination of paper-based and computer-based activities. The use of NVivo™ commenced during the analysis of initial interview data, which was labelled and then coded into descriptive and topic coding in Phase 1 data collection. NVivo™ was used for the storage of transcribed transcripts, photographs of objects and copies of naturally occurring data. NVivo™ was useful for handling large amounts of early codes. In this study, the confounding factors were considered over at micro, meso and macro levels in the context of the source, and how this fitted into the bigger picture.

Field notes assisted in keeping track of developments, and played a significant part in tracking the creation of emergent categories and the progression of themes. Memos and field notes were made of thoughts and reflections during the transcription, in relation to the research questions or familiar repetition of issues that had occurred in other interviews. Field notes contained drawings of mind maps and tables that tested the strength of ideas by collating the evidence for each label and then collating the labels and trying different labels, and finally constructing categories.

The analytical approach of identifying reoccurring issues, similarities and contrasts is a process explained by Ezzy (2002), Yin (2009) and Richards (2013). As recommended by Richards (2013), this type of analytical coding involves examination of the data to locate answers to the research questions. Presentation of analysis starts with labelling data (descriptive), coding findings (topic), and analytical analysis to generate themes (Richards 2013). This approach is known as thematic analysis and was the planned analysis approach.
for this study. Ezzy (2002) identifies that this type of open coding is experimental, and so labels are initially subject to change.

Recurring patterns were identified through an inductive process within and across interviews, working back and forth between data sources. Exploration back and forth across the multiple case studies increased sensitivity to the concepts, until hunches and ideas led to the building of purposive labels that in turn led to categories discussed with supervision panel and returned back to the participants at interviews in Phase 2.

As emergent primary labels were induced from the initial interview data, other supportive examples were searched for across initial interviews and objects and then later across second interviews, field notes, and focus group discussions. Consequently, early labels were subject to change dependent on consultations with research supervisors and until categories are tested and confirmed at second interviews, or explored for clarification or further exploration. Yin (2009) suggests that case study analysis is similar to the investigation performed by a detective as evidence is looked for to support a conclusion, and where an inference is contradicted, additional evidence is necessary to support a claim, and possible justification for the anomaly (Yin 2009).

Collective similarities from Phase 1 transcripts were accumulated to create labels. Data analysis moved to the next level when these initial findings were presented to participants at the second follow up interviews in Phase II. Verification, or clarification was sought for the labels, the further discussion added depth of perspective and provided additional, sometimes more specific, details. For example, the label “support” was investigated at the follow-up interview by asking participants to clarify their narratives shared during their initial interview. Participants exemplified such examples of their role modelling to students or being supported by a senior midwife who had role modelled good practice to them, or how they had supported women to achieve the birth experience they desired. I concluded that in parts of their conversations, “they were talking about relationships with women”, or “they were talking about interactions with peers”, or “they were describing what was challenging”.

These examples were then relabelled as ‘relationships’ that contained two types of interaction: “relationship with women” and “relationship with peers”. The merging of categories led to the construction of themes.
Moving up from the data - analytical analysis

Critical interpretation helped in the development of categories and the development of themes. Reflection on the interpretation of text, and consultation with supervisors, enabled the interrogation of deeper meanings; of contradictions, ideologies, conformity and cultural values in order to consider the different elements of what was said. “Taking off” from the data is the process of thinking about the data in other ways and not just at face value. Asking “What is interesting in what was said?”, “Why is that interesting?”, and “Why am I interested?” led to questions such as “What is the consequence of this thinking?”. These interesting tangents were written up as field notes and some became categorises that later created themes.

Yin acknowledges that it is necessary for researchers to be open to the development of data, and interpret the information as it is being collected: for example, the initial early findings from the data that led to the interpretation that support was something linked to CPD, as evident in the literature. However, further investigation showed support emerged as a construction of situations within practice that influenced the participants in ways that motivated decision making around registration renewal. Hence, “motivation” was themed and published in Publication 1. The categories generated in Phase I identified what was important to participants such as relationships with women, support, and interactions with peers, and how these were all motivating factors in the decisions participants were making about themselves in relation to registration renewal, their roles and practice.

Analysis of objects

Objects in this research study provided insight into the participant’s values in relation to their practice and continuing professional development. Initial descriptive analysis of objects categorised them as either physical or non-physical objects. In the analysis of the accumulated objects, as a collective, I looked for any similarities or stark differences in the selected objects, to extract meanings from the collective. Participants’ narratives were considered in relation to the explanation of their object. Analysis of the physical items such as the uniform badge or the book held professional and educational significance, while thank-you cards and gifts from women were discussed in terms of values of being a midwife. Non-physical objects where participants talked of their own births or the philosophy of midwifery were connected with personal meanings around being part of a profession that respects...
normality in childbirth, while the non-physical object of cannulisation skill was linked to both educational achievement and practice significance. Three headings – gifts from women, mementoes with practice significance and education materials – were developed and used to label both physical and non-physical objects.

**Rigour**
A systematic approach is required to produce rigorous research with credible findings (Morse, Barrett, Mayan, Olson & Spiers, 2002, Houghton et al, 2015). A robust approach to the research methodology and engagement with the research data is required (Balfour, 2001). The research approach and design of this study has been presented in the previous section. Figures 1 and 2 demonstrate a clear chain of events in which the collection and management of the data is made clear (Richards, 2013). This supports verification of the findings. Findings from qualitative approaches grounded in social constructionism are not likely to be reproducible (Morse et al., 2002) however systemic attention to consistent application of procedures for the methodology, and evidence, using a chain of decision making and procedures, enhances the credibility and transferability of findings Consistent with case study methodology informed by social constructionism, this research used purposive sampling (Berg, 2004; Blaikie, 2000; Patton, 1990, 2002), multiple data sources as a means of data triangulation as previously described and prolonged engagement via the longitudinal methods (Houghton 2015). Field notes diarised throughout the data collection and analysis process enhanced transparency. Bloomberg and Volpe (2008) argue that these processes provide an audit trail of evidence. Yin agrees with these actions, saying that audit minimises errors and biases, and increases the credibility of the information collected, the analysis, reflection and formulation of conclusions (Yin, 2009).

Finally a planned, approach to data management and analysis is needed (Richards, 2013, Ezzy, 2002). The transcripts from the phase 1 interviews were returned to the participants in order to confirm the content as consistent with each participant’s intent. The return of transcripts to participants as a confirmation of content is contested (Morse et al., 2002) however it is a process which facilitates reflection on content in follow up interviews in longitudinal approaches such as the one used in this study.
The analysis procedures has been described and summarised in figure 2 which shows how analysis was an ongoing and iterative with categories and initial themes scrutinised and revisited to produce depth and breadth to the final themes. Emergent themes were synthesized and examined against the current literature findings, and these will be discussed later in the findings chapter.

**Reflexivity and the research process**

Social constructionism inferences that meaning is constructed in social interaction (Crotty, 1998, 2003). Research informed by this epistemology requires that the researcher understand their influence on the research, and meanings constructed as a part of establishing the rigour of the research and its findings. Field notes as identified in the previous section, discussions with supervisors and the peer review process constitute actions undertaken in this study which assist the researcher to identify, understand and neutralise their impact. Reflexive practice assists this. (Gough, 2003; Nicholson, 2003)

As a midwife registered with AHPRA, I am confronted with the same issues as the participants in this study, so I am subjected to the same changes that the participants experienced in this study, and share an understanding of the cultural meanings shared by this social group. Being a midwife has influenced how I have engaged in this study. I have reflected on my prior experiences and assumptions, and strived to keep an open inquiring mind to midwives’ experiences. Regular research supervision facilitated this by providing structured discussion around emergent themes. During the data collection and analysis phases, I documented my thought processes and reflected on how I came to any conclusions in order to establish that thought processes were formatted from the presenting data, rather than influenced by any personal experiences, opinions or readings.

My experience of the phenomenon was just one interpretation amongst the many and so my story was not shared with participants, as this could have silenced the collection of their experiences (Gough 2003). Instead, during the interviews, I practised naivety in listening intently to what participants were saying (Nicholson, 2003), and followed up on tangents within interviews to clarify details and check my understanding of participants’ experiences. My opinions were documented as field notes throughout the thesis, providing evidence of my thought processes.
I felt that my identity as an academic at the initial two interviews influenced the focus of the conversation towards education, specifically the CPD standard, as participants appeared to presume that as an academic my interest was on education and CPD. In subsequent interviews, I attempted to privilege my identity as a midwife and PhD student. Nevertheless, participants naturally directed their conversations towards the CPD requirements, suggesting that this was their main focus when establishing their registration renewal requirements. Discussion about RoP was less direct as subliminal meanings about RoP emerged from general conversation or discussions about the objects brought to the interview.

Being a nurse and midwife and being exposed to the same phenomena as the participants meant I had a good understanding and appreciation of the possible issues that may be raised by participants. However, in some cases new unexpected perspectives were raised. The flexible design of the conversational interview technique enabled new issues to be addressed by being open to new leads. For example, one issue related to the registration renewal process that had not been considered to be of interest in this research was the requirement for demonstrating adequate insurance to cover scope of practice, and although the standard of RoP was of interest, the issues that were constructed as a result of their perceptions were unexpected and interesting. Participants also had not considered that the separate registers presented them with choice; the new options of single or dual registrations were significant elements that emerged as part of the phenomenon during the interviews.

The constructionist epistemology appreciates that values are constructed and meanings applied to objects by human interactions. Human interpretation is always subject to context. Each speciality is theory-specific, and laden with imbued meanings. Garrow and Shove (2007) demonstrated this when they compared how practitioners from different disciplines analysed objects peculiar to one another’s field of speciality. Hence, the advantage of my own positioning within midwifery benefits the analysis of this sample’s contributions due to my shared understanding of professional context.

Summary

This chapter has presented a detailed description of the research approach, qualitative design, and procedures. A constructionist perspective permitted the pieces of data to be aligned and built together like a jigsaw to create a contemporary picture of the
consequences of the new registration and regulation standards for these Australian midwives. The benefits of case study design are that it allowed flexibility of design and enables the collection of any data considered relevant in the form of field notes to support and illuminate the participants’ experiences.

The single, embedded multiple case study design enabled each and every participant to be considered as a unique individual so that their story could be analysed independent of one another to tell their unique story. The collective nature of the case study design has also permitted the connection of commonality amongst the experiences of these midwifery practitioners as they experienced the changed registration process as a cultural group. The findings report from two perspectives at micro and meso levels. Chapter 5 presents the findings of this study but first the individuals will be introduced in Chapter 4.
This chapter introduces each participant. Each participant represents a case to form the multiple embedded cases within the one single case study (Yin, 2009). Each participant agreed to be interviewed in Phase 1 and Phase 2. All participants were female and over 35 years. The sample was recruited from the broader Australian workforce from five Australian states: Queensland (Qld), Western Australia (WA), New South Wales (NSW), Victoria (Vic) and Tasmania (Tas).

Participants from each state were given pseudonyms that started with the same letter. For example, all participants from Queensland were given names beginning with “S” (Sam, Simone, Sarah, Siobhan), from Western Australia with an “E” (Eve, Emma), and from New South Wales with an “N” (Nancy, Naomi, Natalie, Nell, Neme, Nicole, Nikita, Nora).

Table 4 provides an overview of the 20 participants who took part in the interviews and informs the reader of their registration type, practice roles and employment status at recruitment and during Phase 1 of the study. The table uses the Australian Standard Geographical Classification (ASGC, 2009) to illustrate practice location.
<table>
<thead>
<tr>
<th>States</th>
<th>Name</th>
<th>Registration Type</th>
<th>Practice Role and Public/Private Employment</th>
<th>RA Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Zoe</td>
<td>RM/RN</td>
<td>Educator, private hospital</td>
<td>Inner Regional RA2</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Nancy</td>
<td>RM/RN</td>
<td>Midwife in public regional maternity unit</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Naomi</td>
<td>RM/RN</td>
<td>Clinical nurse manager in operating theatres</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Natalie</td>
<td>RM/RN</td>
<td>Community midwifery from a public hospital providing care to Aboriginal families</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Nell</td>
<td>RM/RN</td>
<td>Director, regional public maternity unit</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Neme</td>
<td>RM/RN</td>
<td>Coordinator, antenatal clinic</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Nicole</td>
<td>RN/RM</td>
<td>Nurse in public paediatric ward</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Nikita</td>
<td>RM/RN</td>
<td>Nurse in public paediatric ward</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td></td>
<td>Nora</td>
<td>RM/RN</td>
<td>Midwife educator in public services</td>
<td>Outer Regional RA3</td>
</tr>
<tr>
<td>Queensland</td>
<td>Sam</td>
<td>RM/RN</td>
<td>Coordinator, public antenatal clinic</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Sandra</td>
<td>RN/RM</td>
<td>Triage nurse</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Sarah</td>
<td>RN/RM</td>
<td>Nurse Unit Manager in public service</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Sally</td>
<td>RM/RN</td>
<td>Public ante/postnatal</td>
<td>Remote RA4</td>
</tr>
<tr>
<td></td>
<td>Sharon</td>
<td>RM/RN</td>
<td>Midwifery manager in public service</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Siobhan</td>
<td>RM/RN</td>
<td>Independent private practice midwife</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Simone</td>
<td>RM (Eligible)</td>
<td>Birth unit team midwife in public service</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Suzie</td>
<td>RM/RN</td>
<td>Birth unit team midwife in public service</td>
<td>Major City RA1</td>
</tr>
<tr>
<td></td>
<td>Sue</td>
<td>RM/RN</td>
<td>Public community postnatal service</td>
<td>Major City RA1</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Emma</td>
<td>RM (Eligible)/RN</td>
<td>Independent private practice midwife (IPPM)</td>
<td>Very Remote RA5</td>
</tr>
<tr>
<td></td>
<td>Eve</td>
<td>RM/RN</td>
<td>Public antenatal/postnatal</td>
<td>Very Remote RA5</td>
</tr>
</tbody>
</table>
The sample included midwives from a diverse range of practice roles in both public and private settings, working in nursing and midwifery roles; these included education, management, and clinical nursing and midwifery practice. Some people worked part time between positions; for example, a couple of participants held dual positions working in both a public hospital and teaching at university. The independent midwives worked part time in public maternity services to supplement their income until their private practice became established.

The reflections and perceptions of each of these experienced practitioners is a case and formed the basis of the analysis and findings. Their profiles and narratives revealed rich and diverse sources of experience and expertise. Each of the three publications of the findings draws on their contributions in order to address the research questions in specific ways. In order to give voice to their contributions, and provide depth and context to the findings presented in each of the three publications which follow, a short narrative is provided below for each participant. Each narrative is constructed from the personal details collected during the interviews with each participant and information shared in their demographic sheet, which provided details about their qualifications, when they trained and where they worked. I have identified here what I feel was each participant’s most significant contribution to this study, and their plans for their future registration with AHPRA and the NMBA. I have also illuminated their selected object of significance associated with their professional practice.

**Individual Case Studies**

**Zoe**

I met Zoe at a national midwifery conference. At that time she was the Nurse Unit Manager of a private obstetric maternity unit, but she had just also adopted the role as the unit’s midwifery educator for two days a week. Zoe qualified as a nurse in 1983 and a midwife in 1988 after hospital-based, apprenticeship training. She was aged between 50 and 54 years old, and had not undertaken further tertiary education since her initial registration. However, Zoe had engaged in CPD through health service development programmes.
Zoe initially practised nursing full time for five years but after qualifying as a midwife has since practised midwifery full time for the last 20 years. Zoe’s main practice areas have been in birth suite, antenatal education and postnatal care. She said she had never worked in community or in a midwifery-led model of care.

Zoe’s object of significance was an excellence in practice certificate awarded to her after a nomination from a woman she cared for after her working day had finished:

_The feedback form was saying that every time that I was there, and I was, I kept on going back and checking on her because I was really worried about her.... that was nice that she noticed yes, so that was special to me. Not the award, the feedback._

Zoe’s main contribution to the findings of this study came through her narratives that identified how she saw nursing and midwifery practices as separate;

_In regards to recency of practice for general nursing, occasionally when our unit is not busy we do go down to theatre recovery to work with our mothers in recovery but if we are working with our mothers we are there and we sometimes have to help recover patients; look after the general patients too. So, I don’t think I have a problem with my general._

Zoe’s narrative revealed that she perceived nursing and midwifery practice as quite separate and distinct and thus claimed the practice activities of nursing and midwifery separately.

**Nancy**

I was put in touch with Nancy via her regional midwifery educator who had collected some research invitations from a national conference in 2011, and distributed them locally. Nancy had responded to one of these via email. I responded by sending her the information sheet and consent form via her email address to consider. Our first interview, in May 2012, was a phone interview.

Nancy, a woman in her forties, worked as an agency midwife in an outer regional area. She worked 76 hours a fortnight on a full-time agency contract. Nancy worked in an eight-bedded ward with a birth-suite attached at the end of the ward, meaning that on a
normal shift she may care for postnatal and antenatal women, as well as for women in labour.

At the time of the interview, Nancy had been qualified as a midwife for just over a year. Her initial registration as a nurse was in 2003. Nancy had completed diploma level programmes for her nursing and midwifery registrations. Nancy told me her story of how she became a midwife:

*I knew in my third year of nursing degree that I didn’t want to be a nurse. I wanted to become a midwife but I was told that I couldn’t. They weren’t accepting nurses into the midwifery degree in New Zealand. I didn’t delve further into that. I took her word and completed my degree (nursing) and I worked in a little hospital in New Zealand and I then four or five years later came over here to do some agency nursing and yeah .... they were calling for midwifery applications for postgrad you know diploma and I applied.*

In the initial interview, Nancy was knowledgeable about the registration renewal requirements but confused about the exact details. Nancy was aware of the number of CPD hours required but said due to her agency contract she had limited entitlements to CPD, and did not receive automatic access to in-service education training at the hospital, or financial reimbursements.

Nancy did not participate in a follow-up interview, as I was unable to make contact with her to arrange the Phase II interview. It is a possibility that she returned to New Zealand to practise as a midwife as she appeared highly motivated to continue to practice midwifery. Her object of significance was her midwifery books. She recalled:

*I bought them before I did my diploma and so they mark a new stage in my life looking after mostly well women. It’s my dream job, being a midwife... they give me information, I think.... one in particular by Sarah Buckley a GP in Brisbane. That’s the way I would like to do midwifery, be with women, to be natural, and go with the body. I can explain it better by explaining what I want to do. I want to go home and become an independent practitioner.’*
Nancy’s main contribution to this study was the importance she applied to role models, which translated as a significant motivator for her future aspirations, a major focus in paper 1:

*When I was a student I knew what sort of midwife I wanted to be and she was a midwife. I just so wanted to be like her. She was really natural, nothing worried her, she was so calm, and women trusted her and she built such great rapport with them. That would be awesome if I could become as good as her.*

**Naomi**

Naomi qualified as a nurse in 1980 and as a midwife in 1984. Both these qualifications were achieved through hospital-based apprenticeship training. When Naomi first qualified as a midwife, she worked full time for three and a half years before returning to nursing practice. Naomi holds a senior management position in an outer rurally base hospital and works in theatres as the Charge Nurse, but rotates annually to the maternity unit for one month a year to maintain her competencies. In her fifties Naomi has never completed any tertiary education; nevertheless, she provided a long history of professional development through health service courses and conference attendances.

Naomi had a strong belief that her recency of practice was demonstrated through clinical hands-on care. Despite being in a managerial position, she felt that as a leader she should lead by example. Thus she felt her midwifery registration was potentially threatened because the hospital and her role was becoming extremely busy, meaning that she probably would not be able to sustain her secondment to the maternity unit on a yearly basis. Naomi had a good grasp of the national registration renewal standards, but her own personal beliefs of expected professional practice hours necessary to demonstrate competence exceeded the minimal standard set by AHPRA and NMBA, and so she was starting to doubt whether she would continue to maintain her midwifery registration:

*I am starting to feel that I won’t have enough clinical practice to maintain my skills and I am not going to do it if it is only half hearted. I want to be able to go over there and look after a patient and feel confident I am doing the right thing. Saying that, I have always asked questions and asked for help, I don’t mean that. But if I go over*
there and go Oh shit, how do you do that? I am not going to be comfortable (laughter) in that sort of situation I am prepared to stay there and get competent and then I’ll be right, but not as a walk on the ward and can’t do it. I want to be able to walk on the ward and be able to work there like I have been working there. (Phase 1).

Naomi’s main contribution to this study was her perspective on the practice capabilities of herself and others. Her discussion of her object illuminated her views about professional standards and an individual’s responsibility to be accountable for meeting the registration standards. As a manager, Naomi felt very strongly about being a good role model to her staff and leading by example, and she had these same expectations of her staff. Furthermore, she expressed turmoil at the prospect of letting her midwifery registration go as she felt an obligation to be able to step in and help out her peers in the maternity unit, in the event of an emergency or shortage of staff.

Natalie

Natalie originally qualified as a nurse in 1998 and as a midwife in 2002; both these qualifications were diplomas. In her late thirties, Natalie was married with children and worked part time as a community midwife in an Aboriginal maternal and infant health service, providing antenatal, intrapartum and postnatal care three days a week. Natalie was very passionate about her job and had a good working relationship with her colleague, the Aboriginal health support worker. Her object of significance was the image of a breastfeeding woman. This she felt reminded her of the unique bond between mother and infant and she talked about the importance of making space for them.

Natalie’s narratives contributed to the theme “motivation” by signifying how the unique relationship with women can have a subconscious impact on a midwife and play a role in determining how a midwife thinks about her practice. Natalie especially considered that the characteristics of midwifery practice competence for registration renewal required demonstration of “clinical” practice within the hospital setting, especially within the birth suite. The result of these accumulated variants meant Natalie regarded a return to the hospital to complete some clinical practice in birth suite as a necessity to meet the RoP standard for registration renewal.
Furthermore, Natalie expressed confusion about the national registration renewal requirements. She relied on the “grapevine” for her source of information about professional practice expectations. Therefore, she articulated with conviction her narrative about how she saw nursing and midwifery as separate roles as if this is a shared view. Natalie identified how she met the RoP standard for the separate roles by providing examples of nursing-specific activities, such as helping out on nursing wards when they were busy while practice in birth suite was without doubt midwifery-specific RoP. Her tendency to dichotomise events also applied to the separation between her time at work, and her personal, family life. When not at work she saw this time as very separate to work, and was reluctant to engage in CPD on her own time as this she felt was time for her husband and children.

Nell

Nell, a midwifery unit manager in her forties, first qualified as a nurse after an apprenticeship-style hospital training in Australia in 1992. She then completed a degree in midwifery in 2001 in Europe. After a series of moves abroad, Nell finally returned to Australia. She worked in many different maternity services including a busy tertiary unit that birthed over 8,000 women a year. Nell was also experienced in both caseload and team models of midwifery care.

Nell volunteered to be a participant in this study because as a manager she valued the importance of registration and regulation. The first interview was undertaken in Nell’s private office in an outer regional maternity unit, which formed part of a base hospital. As a result of numerous house moves, Nell once lost track of her registration renewal date and was at risk of her registration expiring due to complacency. This, she told me, taught her the value of professional registration. Hence, she was very motivated to ensure that she met the new national standards. Nell was proficient in addressing the standards herself and as a manager was systematically addressing each staff member to ensure everyone had their learning needs met in order to meet the CPD standard.

In her new position as a midwifery manager, she was navigating some challenges that caused her significant stress, one example of the difficulties the unit was facing was caused by staff shortages. Nell’s object of significance was a gift she recalled being given by a woman
she cared for within a caseload model of care. Nell’s object of significance resulted in narratives about how Nell felt:

    It reminds you of the experiences you had with people and the impact, that they thought it was significant enough for them to make this beautiful gift to you, to remind you I suppose... you get chocolates and cards, and the cards you get; the thank-you cards from women when they take the time to write down what it meant to them. I think we are very lucky in our job because we do make meaningful links with women.

The memories evoked by this reflection combined with the challenges she was facing in her current position meant that Nell became emotional during the interview and the recording was paused. As a one-to-one interview, this interaction served a cathartic purpose for Nell. Nell identified that she was aware of the counselling services at her GP and hospital services but was grateful to be able to air her feelings in a safe and confidential environment.

At the follow-up interview Nell had settled into her new role as a manager. She had started a leadership module run by the health service for new managers, and spent a lot of the second interview sharing her new knowledge. However, Nell’s main contribution to this study was the significance of the relationships with women. She felt her work in midwifery models of care taught her how as practitioners we have to be accountable for our actions, and so must maintain competence to provide safe, effective care. This she felt were qualities she should role model for others.

**Neme**

Neme, who was in her early 40s, had registered as a nurse in 1992 and then worked for many years in nursing. However, feeling the need for a change she completed a diploma in midwifery in 2003. Neme was recruited to this study via a snowballing process; her maternity unit manager noted the advertisement at a conference and suggested it to Neme, who then contacted me via email. I sent the information sheet and consent form via return email. Our first interview occurred face to face in May 2012.
I conducted the first interview with Neme in 2012 at the outer rural hospital base where she worked. I asked Neme to explain how she was going to meet the national registration renewal standards. She advised me she was reluctant to engage in CPD, saying, “I just don’t like to study”. Exploration of this comment established that she had an aversion to completing course work and had no plans to study in the near future: “Well I am not doing a course currently... but if I was I’d be damn glad to see the end of it I can tell you”. She did not like to read extensively or undertake on-line web-based independent learning:

I don’t think I read properly. I misunderstand words sometimes when I am reading. I am not dyslexic, but I sort of don’t fully take it in, but when I am listening to someone else lecturing I understand it more clearly...., it’s like I said when I try to read things it doesn’t necessarily sink in for me so I like to go over it again.

However, she did not mind listening to lectures or attending conferences. Neme was single with no dependents and reported being free to fly to cities in order to attend CPD activities at short notice. This freedom linked to her object of significance, which was her holidays. She said her focus was on getting through the shifts until her next holiday.

Neme’s motivation to maintain competence was triggered by her responsibility to women. It was evident that Neme’s professional development needs were being addressed through her requirement to meet the needs of women in her care, as she said she sought information to provide evidence-based care as her need for information arose:

anything I come across in the clinic, and I think oh I don’t know that. I’ll look that up. Or somebody asks me something, stuff like that.

Neme’s main contribution to this study was that her narratives illuminated a dichotomy between nursing and midwifery:

We do have general patients here, medical and surgical, but whether I have done three months in the last five years is another thing.... So, are we supposed to work in another area I wonder? I don’t know.... Like I said, we do have medical surgical patients coming here from overflow so we do get those patients but they are usually fit well patients who require antibiotic or a dressing or something.
Despite attempting to contact Neme via numerous methods between March and June 2013 (email, text and phone calls messages), she did not reply. Therefore, an interview was not conducted in Phase 2. Her name was on the national register as a nurse and a midwife in 2014.

Nicole

I arranged to meet Nicole by telephone and our first interview occurred in May 2012 in a hotel room close to the hospital in which she worked. When we first met, Nicole was in her late thirties and was 34 weeks pregnant. Nicole first qualified as a nurse in 1997 and then worked in paediatrics. She then decided to complete postgraduate midwifery training and qualified as a midwife in 2006. After completing six months practice in midwifery, Nicole returned to nursing where she has worked in a paediatric ward for the last six years. Nicole had dual registration and so I asked her how she would continue to meet the registration renewal requirements for each registration under the national standards.

Nicole’s main work place was the paediatric ward. However, if the paediatric ward was empty or quiet she would be redirected to another location within the hospital and she often requested to go to the maternity unit as this enabled her to maintain her competence in midwifery practice. However, Nicole reported that this option could not be relied upon to maintain proficiency. Nicole expressed her frustration that she had in the past gone to the maternity unit and taken over the care of neonates in the special care baby unit only to be called back to the paediatric ward when a new patient arrived, such as an admission of a neonate with jaundice. Thus, Nicole would care for infants and their mothers to assist with breastfeeding and neonatal care needs in the paediatric ward. Nicole explained the care of these neonates and their mothers as separate practices, using different registrations. Assisting with Breastfeeding she viewed as midwifery, but caring for the neonatal jaundice as nursing.

At our first interview, Nicole informed me that she had plans to change her midwifery registration to non-practising with the AHPRA. At her follow-up interview 10 months later, which was conducted by phone, Nicole had moved to a city and had given birth to a baby boy. She told me she had gone ahead and registered as a non-practising midwife, which
meant that she did not have to maintain her recency of practice or CPD for the midwifery register. She shared her plans for work after her maternity leave:

’I will just see if I can work as an RN on a maternity ward or just go back to paediatrics and then possibly later when (the baby) is a little bit older and at school, then I will be able to do it because I just don’t have any childcare at the moment.

Nicole was used as an example in two published papers to illustrate how practitioners have considered their practice activities in relation to proving recency of practice. For Nicole to renew her registration as a midwife, she will need to complete a return to practice course or assessment, which will incur costs associated with retraining.

Nikita

Nikita originally qualified as a nurse in 1980 and as a midwife in 1985; both these qualifications were certificate-level awarded after hospital-based training. Nikita worked full time as a midwife for eight years after qualifying, and then after having children she has maintained her midwifery practice through occasional shifts in midwifery. Nikita’s current role was as a nurse in a paediatric ward. However, at times when the paediatric ward was quiet, Nikita as a dual registrant was often transferred to the maternity unit to assist in meeting the staffing requirements. This she felt enabled her to maintain her dual registration, recency of practice requirements. However, Nikita, like Natalie, was very unsure about the statutory parameters relating to practice standards, and relied on the hospital “grapevine” and her managers to ensure she understood the registration renewal requirements. Nikita’s contribution to this study supported the contribution of many other participants who were also dual registrants, and who too were uncertain about continuing to keep both registrations up to date, unclear about the requirements, and reliant on the wisdom of those in their organisation. Nikita said that she enjoyed her occasional shifts in the maternity unit, but did have some concerns:

You know I do like working in Maternity now and then, so just to have that little bit of experience to stay there, so I will keep maintaining it, plodding along trying to keep the CPD up, and if they want me to do week here and there. I enjoy it when I am there,
because I pick it up quick enough when I am there. I just don’t want them to expect me to come in all guns blazing into labour ward. I would be happy to keep my hands in so to speak.

Consequently, she had doubts about whether she would maintain her midwifery registration:

For me, I don’t have the incentive... I am sort of sat on the fence at the moment really thinking, will I won’t I?’

Nikita’s object of significance was her midwifery registration badge:

the King George badge and it’s got a cute little picture of a baby in swaddling ... Yeah, I’ve lost that. So that would have been nice if I could have found that.’

Nikita recalled the significance of the badge:

memories of doing the course I guess, remembering when you were there and all the experiences you had to do and the experience you had to gain and getting through the course,

Here Nikita is referring to her initial training. She also referred to the camaraderie she shared with her peers on the training program. Other participants also made mention of the importance of peer relationships. This factored in motivating the decisions that they made about registration renewal.

Nora

Nora had been qualified as a nurse for eight years and a midwife for six years. In her late twenties she had recently started a new position as a midwifery educator, providing education to neonatal nurses and midwives across a maternity service that had a number of different site locations. During the term of this study, Nora completed a Master in Education as part of her professional development as an educator. In her position as educator, Nora felt it was her role to ensure she could provide education to her peers, to provide them with the correct guidance to meet the registration renewal requirements. So in October 2010 she attended a national midwifery conference to increase her awareness of the details of the
national registration scheme and the required renewal standards. Nora’s understanding of RoP was the following:

*The definition says something about three months in the last five years and that’s basically what I go on.*

And her understanding of CPD:

*so at least 20 hours and maybe 40... what might be relevant to nursing might also be relevant to midwifery.*

Nora needed to maintain both nurse and midwife registrations for her educator position. However, her discussion of the national standards showed tensions were evident around the national standards, as participants grappled with the intricacies of their decisions about recency of practice for each registration:

*20 hours is nothin’ in a year, cos I’ve done that in midwifery cos that’s what I’m passionate about. But being a registered nurse first. The biggest challenge for me is doing that for a registered nurse.... the implications of that, the registration part is, [pause] do I, [pause] what happens to my registrations around that?*

In Nora’s six years as a midwife she had worked in antenatal, intrapartum and postnatal services both in and out of hospital. She enthused about her passion for midwifery and spoke extensively about the philosophy and “art” of midwifery:

*I think the value of practice is something you get, well I think, is in hindsight, a little story my dad told me he went to his dentist and saw another dentist, and the nurse said I know you from somewhere, and he said yes you use to be my dental nurse a long time ago and she said oh that right you’re (Nora’s) dad and he goes yeh, and she proceeded to tell him how valuable my practice was to her, and then the dentist’s wife came in and I had also been there for her birth. What I think, what I value in my practice is knowing there are people out there who had a better birth because I was able to be there, not necessarily because I am the best midwife in the world but because my practice is valued by the women.*

*I value the fact that the definition is, the definition of a midwife is “to be with woman” and through that story women believed I was with them so, and that’s what’s valued*
in my practice. I value that “with women” stuff, not having the greatest knowledge in the world or the greatest neonatal skills in the world or the greatest midwifery knowledge in the world, but just being with that woman and that family for that birth in whatever setting, for me, well I work in the hospital, so for me, I think you can get a beautiful with-woman-centred birth. In hospital, it’s just harder to achieve.

Nora’s perspective influenced how she thought about her dual registrations. This was made evident at the end of her discussion about her object. Nora’s object was a bottle of champagne, with which she connected a story about a woman she cared for in labour, but the object also illuminated her feelings about her dual registration:

> Everything was going normally and fine. All the woman wanted was a glass of champagne, and then the baby had complications, and when the baby came out it needed some resuscitation and I could see dad was worried and distressed and I said everything is going to be OK, respiratory system just needs time to adapt and then once the whole thing was through, once the baby was OK I said I think we all need a glass of champagne tonight. Then the next morning when I came back to work there was a bottle of champagne. ’

The significance of the champagne for Nora was that it was the first time she felt like she had made a difference as a midwife:

> I suppose it was the first time... I first started to feel a little bit more autonomous, and started to change from being a nurse because when I first started in training as a midwife I was a nurse and I kept saying to people, yes I know I am studying to be a midwife but I am a nurse, and around that point I started saying no I am a midwife. Now when someone says you’re a nurse, I say no don’t give me that crap, can’t deal with it, don’t want to, I am a midwife, and you feel that you are a midwife, you’ve done all the studying, you’ve got that champagne to say you’re a midwife... I have had bottles of wine and gifts since then but that is the one that sticks in my mind.

Given her position as an educator, Nora planned to maintain her dual registrations in nursing and midwifery. Nevertheless, her narratives provide insight into her values and perspectives of her registration types, with her midwifery registration taking priority.
Sam

I interviewed Sam in May 2012. She was a senior midwife working as an antenatal clinical coordinator. This was a relatively new role for Sam and she was responsible for the day-to-day running of the clinic at a suburban general hospital. Now in her early 40s, Sam had qualified as a nurse in 1983 and as a midwife in 1994, thus she had been practising as a midwife for 18 years. She had completed her initial nursing and post-nursing midwifery training in hospital and obtained certificate-level qualifications that led to dual registrations. Sam had worked part time over the years in all areas of hospital maternity services to accommodate her family priorities, as she was married with two children. Sam responded to an invitation to participate in this research study and invited me to her home to conduct the interview. I asked her to tell me her story of how she became a midwife and what had happened to her in her career to date, and thus how she planned to meet the national registration renewal standards. Sam’s priorities in regards to the decisions she made about her career, and what she valued as important in her midwifery role were focused on woman-centred care. Sam’s perspectives influenced the choices she made about her practice options and CPD study.

Sam was motivated to study a Master in Midwifery to put her on par with the level of new midwifery graduates, and to enable her to seek promotion, which required “the piece of paper”, the postgraduate qualification. Before studying for a Master in Midwifery, Sam had read journals, undertaken in-service training, and attended conferences to keep up to date with professional development. However, the value she attributed to her postgraduate studies was different from what she had anticipated:

*I felt like everybody else. I am a midwife, I am happy with my practice, I trusted my practice... but through my master’s program it showed me that to get from A to B you actually had to know what went on between A and B, so that knowledge and that applied knowledge certainly came out, and it was very empowering to think well I do actually have that knowledge whereas I hadn’t given myself any sort of credit for knowing that. I also think it was quite dormant that you didn’t realise you had that applied knowledge.*
The change in the registration renewal requirements in 2010 led her to reflect deeply on her journey and consider her context in relation to meeting the requirements. In the quotation above, she defined some specific junctures at which she transformed her thinking or behaviour in contrast to a previous time prior to her role change and her post graduate study. Sam strongly believed in, and identified with, the importance of CPD, and benefit of professional relationships in practice.

Sam had a strong desire to share the beneficial qualities she had gained from her CPD with others and spoke of relationships with peers and women in her care, as well as connections across hospitals as a process useful for building professional relationships, helping to gain positive outcomes for women in the form of improved clinical practice.

She identified the important role, senior midwives had played in mentoring her, and so she valued role-modelling behaviour, which contributed to her object of value, which was her “philosophy”. She spoke of support from her supervisor in the form of encouragement and positive affirmation of her qualities. This was integral in influencing Sam’s decision to move to the new position as antenatal clinic manager.

If her role model had not provided encouragement and shown belief in Sam’s qualities and ability to perform the expectations of the new role, she may have resigned her permanent position. In the second interview 11 months later, Sam had completed her master’s degree and had become a grandmother for the first time. She was euphoric for the new mother who she had supported and encouraged. She was proud not only of her new grandchild but the experience and the service they had received from the maternity services to which she belonged.

Sandra

I met Sandra at a conference. She completed hospital apprenticeship courses and first registered as a nurse in the 1960’s and as a midwife soon after. During her nursing career, she had returned to study and had completed a postgraduate diploma and a degree in nursing. For a number of years, Sandra practised as an educator in a maternity unit. Her current position was as a nurse in a call centre. During her career, Sandra had worked in
Australia and overseas. She had practised midwifery in public and private hospital maternity services, providing antenatal, intrapartum and postnatal care to women; although she said she had not had the opportunity to work in a continuity of care model.

Sandra’s story told of many challenges after her registration lapsed. Her registration renewal lapsed. She went through a number of procedures to regain her registration as a nurse. However, her endorsement as a midwife on the register came with conditions.

In 2010 when the existing state and territory registrants were transferred to the national register (AHPRA), Sandra’s challenges in midwifery registration continued. At the time of the first interview, Sandra informed me that her current position was a telephone triage nurse working for a state health service. Sandra explained that

75% of the calls are from child-bearing women, antenatal, occasionally labouring and many puerperal and lactating women and their partners with well or ill neonates.

Despite using her knowledge of midwifery, Sandra was informed by her AHPRA representative that this experience was not allowed to be counted as midwifery practice. Instead they wanted to know

“When did you do your last shift, [in midwifery practise] you have to have worked a shift!”

While Sandra’s current job sufficed for nursing RoP, at the Phase 2 interview she continued to seek out positions which would enable her to validate her midwifery registration.

Sarah

Sarah qualified as a nurse and then as a midwife in 1990, both at certificate level in hospital-based training. Sarah’s story was one of determined commitment. As a single mother, she had maintained her registrations while advancing her academic work. At the start of this study she had achieved a life goal of completing a master’s degree, which enabled her to secure her current part-time position as an academic. Sarah’s object of value was a photograph of her and her friend graduating as it signified all the hard work she had done and how it was worth it in the end.
Sarah had initially worked as a midwife for the first two years after graduation before returning to nursing where she maintained her midwifery competency through occasional use of her midwifery knowledge and skills within her nursing position. At one stage, Sarah worked for a private obstetric unit in charge of a combined midwifery/surgical unit:

*We did the check on antenatal checks, antenatal interviews on private patients as they were all booked for caesarean sections for ridiculous reasons like it is my first baby but the doctor told me I have to have a caesarean because my pelvis is too small. I was in charge of that for about six months and then went back to emergency because I wasn’t qualified to be in charge of a midwifery unit but they had no one else, they didn’t have any other midwives.*

At the first interview Sarah was working in two positions: as a clinical nurse in charge of nursing in a busy suburban area, and as a part-time course co-ordinator teaching nursing at university. Sarah’s main contribution to this study was in her managerial position as a nurse. She felt it her responsibility to be able to answer staff questions about registration renewal requirements and thus was motivated to find out what the standards were and what that meant to clinicians. Her narratives provided examples of how nurses in practice are responding to the statutory conditions and thus added depth to the data collected in this study. Sarah, in her role overseeing the different areas of the hospital, was often called upon to assist in emergencies at the birth suite. This practice she would use to declare her competence to maintain midwifery registration. Sarah had aspirations to travel around Australia in the future and so plans to maintain both registrations.

**Sally**

I first met Sally at a national conference in October 2011. She agreed to be the first person to participate in this research. Sally was in her early thirties and had been a registered nurse since 2004. She completed a diploma in midwifery in 2007 and had practiced full-time midwifery for the last four years. Her midwifery experience covered team midwifery, birth suite, postnatal ward, antenatal care and education, neonatal intensive care, and home visiting services. Sally worked in a remote region, which meant that her community midwifery
practice was very isolated from access to opportunities for CPD. Therefore, she was attending the ACM conference to gain understanding of the details of the national registration renewal standards. Before the conference she had left her isolated community to seek practice experience performing five births in a busier maternity unit in order to enable her to meet the recency of practice standard. Sally was a very motivated participant who narrated that despite her misunderstanding she was the one from whom others sought information and so she felt she needed to be knowledgeable about the new national standards before returning to work after the conference.

At the first interview, Sally explained that she was due to move into her new position as a community nurse (CNC), which would involve working from a community health centre to develop and provide antenatal and postnatal care. This service became very successful and Sally collaborated with general practitioners to increase continuity of care for women across the midwife–GP partnership. However, when she went on leave other midwives within the establishment were reluctant to provide cover in the community service. Sally was very frustrated with the lack of enthusiasm of other dual-registrant midwives and felt that she was the only midwife dedicated to providing women-centred care. Her narratives reported her ambition to extend the services for women and eligibility was an attractive opportunity. However, she felt the challenge was that the lack of birthing services prevented her meeting the standard for the endorsement for eligibility.

Sally’s object was a stone with the word “abundance” on one side and on the other side the image of a pregnant woman. This object ignited her enthusiasm for midwifery and triggered narratives that formed her main contribution to this study, which was her perspective on “real midwifery” and being the best midwife you can be.

**Sharon**

Sharon was a midwifery manager of a birth suite at a busy major city hospital at the time of the first interview. She qualified as a nurse in 1980 and a midwife in 1982 after hospital-based training; later Sharon studied for a master’s degree. Sharon was aged 50-54 years old and had worked full time as a midwife for over 29 years and practised in all areas of the hospital maternity service. She has no experience of working in the community, or
working in midwifery models of care that provide continuity of care. So Sharon’s main contribution to this study was from the manager’s perspective on the response to the introduction of national registration. Sharon believed dual registration was vital for the continued provision of hospital services. She also identified her personal commitment to lead by example and endeavoured to maintain her recency of practice by engaging in clinical activities within the birth suite that would attest to her competence as a midwife.

Her object of significance that she shared during her Phase I interview was the “clinical skill of cannulisation” that she had just mastered. This was important to her, first because it had taken her so long to acquire the accreditation, and second for the significance of being able to assist the staff with clinical skills and streamline the service for women.

**Siobhan**

Siobhan, aged 45-49 years, qualified as a nurse in 1989 and midwife in 1991 at diploma level, studying later to master’s level. Siobhan became an academic after practising clinically in nursing initially for seven years followed by midwifery practice for almost 14 years. During her midwifery practice Siobhan worked as part of a team providing antenatal, intrapartum and postnatal care. Siobhan had also worked in the neonatal unit and provided post-registration education to staff in the hospital setting. In her current role, she taught undergraduate and postgraduate students.

Siobhan was knowledgeable about the new registration requirements and explained eloquently how her expertise in nursing and midwifery was used within her role on a daily basis, sufficient to maintain her recency of practice on both nursing and midwifery registers. Furthermore, her regular research to prepare her lectures met the CPD requirements over and above the statutory hours.

Siobhan’s object of significance was non-material:

_The object I thought of is my memories. As I don’t place any value on any personal objects, everything is internalised rather than projected externally so personal memories are important to me...personal memories of my own births are important to me rather than any supervised births. My own births were how they [birth] are_
supposed to, how they should be. They were normal and physiological opposed to abnormal. You don’t see that very often in hospital... Because they were normal and physiological they remind me that birth should be normal. Having that experience really grounds you and enables you to recognise deviations from normal when you know the normal very well.

Siobhan’s contribution to this study is that she is representative of midwives who demonstrate her use of both registers outside of the clinical setting.

Simone

Simone was the only single registrant participant in this study. Simone, aged 35-39 years, qualified as a midwife in Europe in 1997 with a Diploma in Midwifery. She later studied further to achieve a master’s in midwifery. Simone has practised full time as a midwife for 13 years and part time for two years. During this time, she has practised abroad in Europe and New Zealand as well as in Australia, providing care to women during their antenatal, intrapartum and postnatal periods, in and out of hospital settings. She has experience of working in independent midwifery practice, and in hospital settings in team midwifery models abroad, and now has her own independent practice in Australia.

At the time of the initial interview, Simone was politically active in midwifery matters in her local area. She was working independently 0.5 full time equivalent (fte) providing private midwifery care in an all-risk model and also providing mentorship to other midwives new to private practice through a state-wide private practice project run by Midwives Australia. Simone was also working for the health service 0.4 fte and had been seconded to a steering committee to advance the agreement to implement visiting rights for private midwives, so they can access the hospital to provide care for their women during labour.

Simone was too busy with her caseload and extracurricular activities to complete a follow-up interview, but her main contribution to this study was her perspective on the change to national registration standards from an independent midwife’s perspective. Despite being fully aware of the standard requirements, her concerns were with the CPD standard. With few resources for back-up, potentially independent midwives in the future
could face challenges in attending conferences and other CPD activities due to their commitment to women to be on call for their birth.

Simone’s object of significance was her independent private practice (IPP) logo:

*I met amazing people on my journey and so each of them has a place in my heart and their journey has a place in my heart.*

The other ones I value very much because they are the ones that shaped me as well, and hopefully contributed to make me into a better practitioner... we are a tool to families and so I don’t think that the woman doesn’t value me if she doesn’t remember my name, or they don’t remember my face. So for me it is the highest achievement if in 30 years the woman says I had a really good experience. And if she doesn’t remember my name, I feel that actually it must have been so healthily about them and gives me immense satisfaction. But yes, I do keep certain things that I do look back on, photos or well one thing I have carried with me, and slightly changed it, is actually our logo, the one I developed for precious life midwifery service...developed in Germany... I call it the big fat lady but it’s something that even though I have changed it to what I felt looked better; that so much symbolises for me that it should be about a joyful time in a woman’s life and so when I look at that I try to.... I also use it on things I give to women as a memory for what they have achieved and how strong they are and what great mums they are .... family strength and what potential they have. So that’s a symbol for me to bring it all together.

**Suzie**

Suzie, in her late thirties, was married with three children and had completed midwifery as a postgraduate diploma course after been a nurse for six years. At the time of the Phase I interview, Suzie had practised midwifery within hospital maternity services for the last 12 years.

At the time of the initial interview Suzie was working full time in a busy city hospital providing continuity of care in a midwifery model team delivering antenatal care, birthing
women in the birth-centre, and then providing postnatal home visits. However, during this study she also transitioned during the length of this study into independent private practice (IPP) with another midwife. During the course of the interviews, Suzie provided narratives about her journey through the MPR process, her challenges of setting up an independent practice, and the challenges and opportunities the changed legislation have afforded her in accessing eligibility status and Medicare benefits for women. Her object of significance was the portfolio folder she had prepared for the MPR process.

Sue

Sue, in her early fifties, worked privately at a number of chemists providing postnatal services to women and their babies. She qualified as a nurse in 1982 and as a midwife in 1987 both after hospital-based training. Sue practised full time as a nurse for 10 years and over the past 15 years worked part time in nursing and midwifery. During her full-time work, Sue practised in the neonatal unit:

> A lot of my practice was in neonatal intensive care but that’s not where I wanted to be, but that’s where they put me because I’ve got previous clinical experience in intensive care. So the delivery stuff I haven’t done that many deliveries since my training.

Sue’s contribution to this study highlighted the significance of individuals’ interpretations of national standards, and her contribution has been vital in illuminating the issues caused by misunderstandings. Sue raised this issue in her desire to gain access to the hospital to achieve recency of practice in order to meet the registration renewal standards.

Sue’s object of significance was a gift from a woman whom she had cared for during the birth of two babies:

> One object that comes to mind is a crystal tree with two different crystal stones. One of my mums gave it to me; she had two babies. It had a beautiful saying...

 interconnected the kids are bigger now
Sue narratives suggested that her interactions with women are motivational, and suggest the type of CPD she engaged in. This is made clear in Publication 1 in *Nurse Education Today*.

**Emma**

I met Emma in May 2012 at a conference in Melbourne. Emma responded to an invitation distributed at the conference. She qualified as a nurse in 2004 and then studied midwifery at diploma level and registered as a midwife in 2006. Emma lived and worked in a very remote hospital, which accepted low- to medium-risk women to birth. The hospital performed less than 1300 births a year. In her position Emma reported feeling confident to meet the registration renewal standards as she had recently completed a master’s degree. Emma worked across many hospital services, including the neonatal unit, gynaecology, birth-suite, postnatal, antenatal clinic, neonatal intensive care and community home visiting service. She described her practice as nursing and midwifery practice.

At the initial interview in Phase I, Emma shared that she had aspirations to work in private practice and had taken actions to work towards gaining an eligibility endorsement on the register in order to become an independent private practice midwife. Emma had completed the Australian College of Midwives (ACM) Midwifery Practice Review (MPR) process and had taken steps to gain access to MBS rebates for women. She also had plans to seek a PBS qualification. Emma shared her object of significance at the initial interview:

*Well, my synopsis would be my most relevant one at the moment. Preparing for my MPR took quite a significant amount of time. I had to develop a midwifery philosophy for the first time ever so that was interesting to get that down on paper. And knowing that, that will evolve as my practice evolves yeah. Formalising that with my competencies and my CV it took quite a time so it is valuable to me at the moment.*

I clarified, “So did you get a certificate? Or is it the portfolio of evidence all together that is valuable?”

*Yes, it’s all of it, all there together, and then you get sent your midwifery practice review certificate and so that goes into your portfolio, and then APHRA sent a letter identifying that I have a notation on the register.*
At her follow-up interview, Emma had been working in private practice for a while; she was supporting women to birth in locations of their choosing either at home or in the hospital. Emma had an agreement with her local hospital to work as a casual employee if she took a woman into the hospital. This enabled Emma to continue to care for the woman, but also met the hospital’s requirements to cover her for insurance purposes for the intrapartum care. In the Phase II interview, Emma brought me up to date on the latest changes:

*I started taking on clients beginning of November 2012, ... I had set up with two other midwives .... I had intended to be full time in private practice, but as it so happens there are certain issues around the politics and the credentialing and things like that, we have actually decided to put the private practice on hold for an undetermined amount of time at this point, until the credentialing is set up, ... I am not in a position to continue working at this time when essentially there is no financial gain at the moment. I am a bread winner and so I can’t afford to continue working for the love of it. So I am bit sad.*

At the Phase II interview, Emma expressed remorse, and appeared defeated by the bureaucracy of the politics of insurance cover and lack of visiting access to independent midwives. However, opportunities had arisen at the local hospital in response to the national maternity plan objectives. A new midwifery team model of care had been introduced and Emma had been successful in obtaining a position that would enable her to have a paid contract for the hours she worked.

**Eve**

Eve was a married woman in her late forties. She had three children and worked in a casual part-time contract, rotating to labour and postnatal wards and the antenatal clinic. Prior to completing a Postgraduate Diploma in Midwifery she had practised as a nurse for 21 years. Eve completed her midwifery training at a private obstetric-led maternity hospital. Soon after she qualified, she moved to a public hospital as she felt this provided more opportunity for her to develop midwifery-led practices. Eve had been qualified as a midwife for four years when I met her. She responded to an advertisement flyer that she saw at a national midwifery conference.
Eve was concerned about the changed conditions, as despite her being an avid reader and very motivated to maintain CPD, she had received major neck surgery the previous year, which had incapacitated her and so for medical reasons she felt she was unable “to keep my points up”. When I met Eve she was attending a pre-conference workshop, prior to the main conference in a bid to complete extra CPD, as she was concerned that she may not be able to meet the 20 hours for each register because she reported she had not completed sufficient hours due to personal illness. Eve’s object of significance was a collection of thank-you cards she kept:

Well I have some cards and things from when I first started off that said the women felt relaxed and comforted and they felt they received a lot more education and understood what they were going through more.

Eve defined some significant differences between nursing and midwifery practice while discussing her objects:

... and you don’t get told off for sitting down and talking to women, anymore. You know when I did my initial registration, it was task orientated and you had to be seen as busy and doing a task. You couldn’t sit down and talk to people, you couldn’t like to listen to people and hear their situation, you had to be seen as busy doing a task.

Before returning to the meaning of her object:

So that for me was a huge compliment and I found that was very important to me and if I am a bit rushed I think now what did those women like about me, what did they actually say? What did they want me to do, it’s just a matter of slowing down and going OK big breath, ask them what they want you to do? You know sometimes when things go wrong they just want you to say sorry. If you don’t say sorry it turns out to be a huge internal investigation, just because you didn’t say sorry.

Eve had aspirations to become an independent private practice midwife, but her main challenge around gaining an eligibility endorsement was that she was unable to accrue the desired practice across the full continuum of childbearing. Eve held a casual contract at the hospital because her husband worked away and she had dependent children. Her casual
contract was a source of trouble to her as she reported it limited her exposure to certain areas of practice.

At the Phase II interview, Eve informed me that her husband’s working situation had changed, which meant that she was able to pursue her goal of expanding her practice experience. Thus, at the final interview Eve advised me she was travelling to another state to work full time as a midwife across the continuum of maternity services.

These narratives share with the readers something of the story and experiences of the study participants regarding their roles, practice and meanings around registration renewal requirements. Their stories form the substance of the findings of this study which are now presented.
Chapter 5
Findings

This chapter presents the findings of this research investigation as three published manuscripts in peer-reviewed journals. The findings from this research have generated new knowledge that has been provided to the profession. Each of these papers addressed one or more key themes that resulted from the analysis.

Paper 1 presented findings that identify how midwives were thinking about the choices they made in regard to continuing professional development. Motivation was a central organising theme, where self-assessment of competence or relationships with women or peers (or a combination of some of all of these) motivated the selection of CPD activities as individuals considered their past, current and future career plans.

Paper 2 is about recency of practice (RoP) decision making. Self-reflection on personal ability to claim competency to renew registration for the nursing and midwifery registers saw participants evaluate their ability to demonstrate RoP based on where they worked, in or out of a hospital setting, place of work, and type of practice. Some tension was found in the construction of evidence of RoP that resulted in confusion both at the individual and organisational levels. This paper presented potential issues for workforce planning.

Paper 3 presents three themes emerging from the full analysis. Themes of rotation, restriction and extension signify the perspectives of midwives as they made meaning of the changed conditions at practice level. It is argued that the findings present construction in which categories of midwifery practice have the potential to impact on the maternity services at large.

These papers are presented in their published format with authorisation from the journal publishers.
Publication 1: Continuing professional development and challenging re-registration requirements: Midwives’ reflections


Appendix (K) Publishers permission to print Publication I
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Continuing professional development and changed re-registration requirements: Midwives' reflections

Michelle Gray *, Jennifer Rowe, Margaret Barnes

University of the Sunshine Coast, Maroochydore, Queensland, Australia

SUMMARY

Background: In 2010 new legislation in Australia led to the establishment of the Australian Health Practitioner Regulatory Authority standards, now used to manage nursing and midwifery registration and the annual re-registration requirements for midwives and nurses. These clearly articulate the continuing professional development (CPD) requirements, together with a guiding framework. Individuals need to engage in adult pedagogy, which makes explicit the need for self-examination to identify and prioritise their learning needs.

Objectives: This study aimed to investigate how existing registered midwives approach and are challenged by these changed statutory requirements in Australia, particularly completion of CPD activity.

Design: This paper reports the findings from phase one of a two-phase, longitudinal, case study in which midwives describe their experience during in-depth qualitative interviews.

Setting: Australia

Participants: A sample of 20 female participants was recruited nationally from four states using a purposive sampling approach to provide maximum variation to explore the issue.

Methods: Each participant took part in an in-depth interview. In order to facilitate reflection on experiences each participant was asked to discuss an object that held professional value or meaning to them.

Results: A key theme in the findings is the relationship between motivation which influences the decisions that midwives are making about CPD, their ongoing registration and practice context. The findings reveal implicit values and beliefs about practice relationships and how these function as motivational factors that influence midwives’ decisions about CPD and practice options.

Conclusions: The findings provide insight into the need for systematic dialogue to devise ways to support midwives to maintain as well as to continue to develop their practice, through CPD and to acknowledge the challenges faced by those midwives who currently hold dual registration as a registered nurse in the context of the changed requirements.

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Introduction

In 2010 legislation in Australia changed (Health Legislation Amendment, Midwives, Nurse Practitioners Act, 2010) which has influenced the regulation of nursing and midwifery. In particular this change led to a shift from state-based legislation to national legislation and regulation, and the creation of separate registers for nurses and midwives. Previously, nurses were endorsed on their nursing registration to practice midwifery. The new legislative environment has led to the establishment of the Australian Health Practitioner Regulatory Authority (AHPRRA) and a number of new registration standards in both disciplines. These standards are managed in nursing and midwifery by the Nursing and Midwifery Board of Australia (NMBA); standards cover competency to practice, evidence of continuing professional development (CPD), proof of recency of practice (ROP), and insurance details. In Australia practitioners may hold dual registration as nurse and midwife but must meet the requirements for each register to maintain registration. The impact of these changes has international interest and significance for midwifery ongoing professional development and workforce makeup. Globally, for workforce planning purposes, there is strategic action to regulate practice and to promote the standards for education and ongoing professional development in midwifery (International Confederation of Midwives, 2011; World Health Organisation, 2010).

In Australia, prior to 2010, registration requirements were State or Territory base. However, since the regulatory changes a practitioner must demonstrate completion of 20h of CPD activity for each registration in order to renew registration each year (Nursing and Midwifery Board of Australia, NMBA, 2010). The Standards now clearly articulate a requirement for nurses and midwives to take responsibility for deciding what education is relevant to them by planning to meet their learning needs and be responsible for ensuring they complete the required number of hours, and demonstrate reflection on learning in order to...
show the value of the learning and its effect on their practice (Nursing and Midwifery Board of Australia, NMBA, 2010). This paper considers one aspect of these changes: continuing professional development (CPD). Midwives have a legal, regulatory and ethical obligation to remain up to date and informed about the best current evidence for care and to implement critical review of their practice as part of CPD (Sandin-Bogo et al., 2008; Nursing and Midwifery Board of Australia, NMBA, 2010, and International Confederation of Midwives, 2005; Australian Health Practitioners Regulation Agency, AHPRA, 2010). A range of benefits are attributed to postgraduate education, clinical practice experience and CPD and are described in the literature. They include increased confidence, choice, autonomy, increased motivation and skills for lifelong learning (Ellis and Nolan, 2005; Spencer, 2006; Veermah, 2004; O’Shea, 2003). Education can provide a transformative turning point (Mezirow and Associates, 2000) leading to increased practice confidence and competence (O’Shea, 2003; Nichol and Webb, 2006). Engagement in CPD enables midwives to respond to the demands of practice efficiently and effectively (Spencer, 2006). A dichotomy between the values of academic education versus the significance of clinical practice learning is addressed by Low and colleagues (2007). Consequently, the decisions adults make are influenced by adults. Needs to know how they need to learn something, and so individual learning outcomes will be dependent in part, on individuals’ choices about engagement in the learning activities (Rase, 1995). So the literature suggests that motivation and values influence the choices and decisions made about CPD, based on the significance to individuals.

We currently do not know what decisions midwives are making about CPD, registration and practice options considering the requirements in the new system and considering the Standards for each discipline. This novel situation creates one reservation for midwives. We investigate how existing registered midwives approach and are challenged by these requirements, and importantly, what influence these have on their practice, its quality and context.

Dual registration, diverse practice roles and career pathways in Australia represent some of the complexities influencing midwives’ decisions and actions in response to these requirements. This change in re-registration requirements could create a turning point for some individuals in their professional life. Understanding midwives’ responses to the changes in re-registration requirements will provide direction for health service and education providers for CPD and workforce planning.

The Study

Aim

This study aimed to investigate midwives’ responses to the changes in re-registration requirements in Australia in a contemporary exploration of midwives’ decision making and reflections on the effects of registration, CPD and practice in the period following the regulatory changes. In this paper one question is addressed: What decisions are currently registered midwives making about their CPD, re-registration and practice context?

Design

A case study design was used to enable a focused in-depth investigation of the phenomenon (Yin, 2009; Stake, 2005, 2008). Case study methodology permits collection of data from numerous sources. This case study used a qualitative and longitudinal design conducted in two phases. This paper reports the findings from the first phase data collection conducted in the first 12 months following the regulatory changes. The focus was on participants’ understanding of the changes, the value to their practice and their decision making during this period, particularly in regard to CPD. The second phase collected data to further explore the impact of the changes on participants’ practice, registration decisions and ongoing professional development.

Participants

Participants were recruited nationally from four states using a purposeful sampling approach to provide maximum variation to explore the issue thoroughly (Blen, 2004, 2008). Following institutional ethical approval for the project (S/11/160), participants provided written consent. Convenience procedures were used to recruit currently practising registered midwives working in any clinical, education, or management role in either public or private settings. Participants not registered as midwives with AHPRA June 2010 were excluded from the sample. The sample consisted of 20 female participants. One participant held single registration as a midwife, the remainder held registration on both nursing and midwifery registers as nurses and midwives. The demographic profile is set out in Table 1; 2 participants were under 30 years, 5 participants were under 40 and the other 13 reflect the workforce demographics with the average age 40.7 years (Australian Health Workforce Advisory Committee, Awac, 2002). Table 1 also identifies the participants’ practice settings and roles. This demonstrates diversity in setting across private and public health services. Participants also worked in a range of roles; 9 worked in nursing positions, 15 were practising midwifery. Of the participants, 13 were in primarily clinical positions, 4 in worked education and 3 in management.

Data

Each participant took part in one in-depth interview, conducted between October 2011 and April 2012. A conversational approach was adopted to generate in-depth explanations of meaning about the phenomenon (Rubin and Rubin, 2005). As part of the interview process each participant was asked to discuss an object that held value or meaning to them in their practice. Objects can assist in accessing meaning during the sharing of experiences (Atkinson, 2002; Bell, 2010). The use of objects in research originates from qualitative approaches in social sciences where visual material has been used as an integral part of the research process whether as a form of data, a means of generating data, or a means of representing results (Knowles and Sweetman, 2004). In this study the objects assisted to elicit information and to add depth to a participant’s description of their experiences and

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Participant’s main practice role: registered nurse/registered midwife, service context and practice type, service type area and context.</th>
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</thead>
<tbody>
<tr>
<td>Age range</td>
<td>Main role</td>
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<tr>
<td>25-29</td>
<td>Midwife</td>
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<td>25-29</td>
<td>Midwife</td>
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<tr>
<td>30-34</td>
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<td>35-39</td>
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<tr>
<td>50-54</td>
<td>Midwife</td>
</tr>
<tr>
<td>60-65</td>
<td>Nurse</td>
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</tbody>
</table>
decision making in the current change environment. Objects take various physical or non-physical forms: they have been described in the literature as physical (Carrow and Shove, 2007), visual (Berlin and Calistrout, 2010) and forms of verbal expression (Molina and del Rio, 2009).

The objects selected by the participants for discussion were varied and included memorabilia connected to study; gifts from women (clients), images and memories of experiences. Regardless of the object, participants consistently told a story to explain their object’s significance. The reflection generated by discussion of the objects gave insight into the values held by the participants in relation to their practice, and subsequently values associated with CPD were explored. Table 2 identifies the type of objects used in the interviews. Physical forms included gifts and mementos as well as educational materials; non-physical objects included a range of verbal memories.

Analysis

Interviews were transcribed verbatim. Analysis was performed initially by hand in an iterative process in which data were labelled within individual interviews and then across interviews. NVivo software (Beecheyzen et al., 2010) was then used to manage the labelled data and facilitate comparison of labelled data across the interviews. This facilitated the collation of data into categories and preliminary themes.

Rigour

Participants were given the opportunity to review their transcript to confirm or refuse any narratives. Consultation was performed with research team members to confirm categories.

Findings

Motivation emerged as a core theme. This theme underpinned midwives’ narratives about their approach to CPD and influenced their decision making in respect to continuing dual registration or reverting to single registration. Three categories inform this theme; participants were motivated by their relationships with midwives, relationships with their peers and by their self-assessment of their competence.

Table 2

<table>
<thead>
<tr>
<th>Objects chosen by the participants</th>
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<tbody>
<tr>
<td>Physical objects</td>
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<tr>
<td>Gifts from women</td>
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<tr>
<td>Bottle of champagne</td>
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<tr>
<td>Tree ornament</td>
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<tr>
<td>Gift of purple box</td>
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<tr>
<td>Card from women</td>
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<td>Photo and letter from woman</td>
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<td>Letter from woman</td>
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<tr>
<td>Memories – practice significant</td>
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<tr>
<td>Stone of abundance</td>
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<tr>
<td>Ingot image</td>
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<tr>
<td>Breastfeeding image</td>
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<tr>
<td>Educational materials</td>
</tr>
<tr>
<td>Skill of cannulation</td>
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<tr>
<td>Graduation photo</td>
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<tr>
<td>Graduation photo</td>
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<tr>
<td>Midwifery text</td>
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<tr>
<td>Badge from initial training</td>
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<tr>
<td>MPR folder</td>
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<tr>
<td>Non-physical objects</td>
</tr>
<tr>
<td>Experiences of clinical practice skills and knowledge in nursing</td>
</tr>
<tr>
<td>Memories of own birth</td>
</tr>
<tr>
<td>ACM philosophy of midwifery</td>
</tr>
<tr>
<td>Experiences with birthing women and new mothers</td>
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</tbody>
</table>

Motivation – Relationships with Women

Midwives revealed that they receive recognition and validation of the important role they play from women. They recalled experiences of relationships with women and discussed how this influenced their midwifery practice, which in turn motivated their choices around CPD to maintain their competence. Nell’s (pseudonym used for each participant) object of value was a gift from a woman she had cared for:

‘In the last week something of value to me has been a purple box by Crabtree & Evelyn that a lady gave to me last year and that made me think about the relationship I had with her because it reminds you of the experiences you had with people and the impact... I think we are very lucky in our job because we do make meaningful links with women. A lot of the time it is not acknowledged or recognised’ (Nell).

This relationship was a strong organiser for Nell, a midwifery manager, who acknowledged the importance of her experiences with women and patients as they motivate her to maintain both her nursing and midwifery registrations. She was undertaking a management course as her CPD, not only to improve her practice but also importantly to influence other staff she managed.

Many midwife participants identified that their incentives for CPD were based on the value placed on being the best midwife they could for women by maintaining midwifery competence or improving clinical skills. Sally shared her object of value and spoke of its importance to her in relation to her philosophy of midwifery:

‘It’s an oval shape, flat piece, on the topside of it, is a sculpture shape of a naked pregnant women. On the back is engraved the word Abundance. I think abundance to me is everything a woman is... an abundance of love, an abundance of belly... an abundance of milk to feed that baby, and that’s I guess something I quite admire.... What I value in my practice is knowing there are people out there who had a better birth because I was able to be there, not necessarily because I am the best midwife in the world but because my practice is valued... women believed I was with them’ (Sally).

Sally’s narrative is representative of many of the conversations generated by objects, and their values around practice and CPD. Emma shared her Midwifery Practice Review (MPR) portfolio as her object of value to discuss her aspirations to become a full time independent midwife:

‘the MPR is because I want to be an independent midwife ...... I just want to give my women the best and for that having recency and doing recency of practice and showing that you are doing evidence based care.... that’s why I continue my study. It’s for my women so that they get the best care possible’ (Emma).

Sally and Emma’s motivation for CPD was inspired by the needs of women. Relationships with women were significant catalysts for participants when selecting practice and CPD options. Sharon identified her chosen object of value was her newly acquired skill of intravenous cannulation:

‘I would say my IV cannulation skill I know it’s not essential for midwives to do that but it’s good to provide a more holistic service to women and it’s taken me nearly 10 years to get authorised... a couple of weeks ago I blew a few veins, but this week and last week I got four out of four. So that’s sort of my thing at the moment, getting that right. That’s what I value at the moment, so in an emergency I can support that woman fully.’ (Sharon)

Talking about their objects helped these midwives describe their ideals, reflect on their practice, and identify future plans. Midwives were passionate about providing the best care possible for women.
Motivation — Relationships with Peers

Peer relationships appeared to play a part in motivating individuals to engage in CPD and maintain competence. Characteristics of supportive peer relationships were friendship, feeling valued and part of the team, receiving acknowledgement and guidance. Recollection of personal experiences were stimulated by photographs that triggered memories of the camaraderie and support shared with a peer during tertiary study which were expressed with pride by a number of participants:

“I have some photos of my graduation… with the girls I did my training with… because we have a common bond of what we went through together… and that photograph on graduation day is like yeh! We made it” (Nicole).

“We graduated together, and it was so good having that person there, we’d talk everyday about our assignments and how we were going and having that support person there is always great when you are studying” (Sarah).

Sarah and Nicole explained how their photographs held personal and professional meanings; their stories exemplify internal and external motivation. Sarah expressed personal pride at her academic achievements and wanted others to experience that too and her reflection on the centrality of supportive peer relationships in these motivated her to assist her peers:

“I like to offer other people in the workplace lots of support in terms of their own study” (Sarah).

Peers such as Sarah were referred to as role models; professionals that participants aspired to emulate. Admiration for peers who displayed desired behaviours leads individuals to evaluate their own personal learning needs and CPD, in turn enabling participants to achieve their aspirations, as identified in the following narrative:

“I would look at somebody’s practice and you thought gee I want to be like that person, what is it that, that person does? … wow she is such a fantastic person I wish I could do something like that… How do I get like that?... knowing how much I valued mentors or midwives who had helped me along in my journey, …you do look for role models and base yourself on them, I want to be that for those people around me” (Sam)

Sam’s object of value was verbal iteration of her experiences which have shaped her philosophy of care. She talked about supporting and encouraging others, both women and midwives, and discussed the importance of providing guidance to peers and women alike.

Zoe’s object of value was a letter of commendation that was written about her from a patient:

the hospital I work in have just started a nursing excellence award... I was nominated this year... that’s not what was special to me, what was special, was that I was sent the feedback form about me... and that was special because I remember this woman... the feedback form was saying, that every time that I was there... that was nice that she noticed me, yes that was special to me. Not the award. The feedback... What could have been a really horrendous and negative experience for her she remembers positively so and that’s the best sort of feedback” (Zoe).

Zoe went on to discuss how colleagues were approaching the responsibilities to complete their CPD hours for re-registration, highlighting contradictory motivations around CPD:

“I have had an onslaught in the last month before registration, “how do I get more points”, “I need more points”, “what can I do to get more points?” … it’s not about the learning, I had one midwife who went off and did RANZOCG CTG workshop three times in a year at different sites to get more points. I said, “I don’t think it works that way”. She said, “no, no, no, it’s all about getting the points” …” (Zoe).

Despite maintaining their CPD activities in midwifery, three participants working in nursing roles faced the prospect that they may have to resign their midwifery registration.

Motivation — Self Assessment and Being “up to par”

The interviews were strongly reflective in nature and the use of objects stimulated reflection but also helped participants to reveal how they were self-assessing their competence to practice in the changed environment and how this assessment was informing their actions and decisions.

Sue’s object was a gift from a woman, an ornamental tree made of metal that had two types of precious stones as the leaves. These leaves represented the two children the woman had birthed; both while being cared for by Sue. Sue identified the importance of supporting women postnatally but she went on to explain:

“I am behind... the delivery stuff I haven’t done that many deliveries since my training and I really felt… (pause) I could deliver a baby in an emergency if I had to... I would feel nervous going back into delivery suite, I would like to do it a few times to get back up to speed... just making sure you stay relevant. I don’t feel I would qualify as a registered midwife to go back into the delivery ward without having some sort of retraining” (Sue).

Personal assessments such as Sue’s highlighted the importance of their practice to support women and their reflection on their competence across the practice skills they required rather than on hours of CPD completed.

Naomi’s object was verbal; her professional experiences (nursing and midwifery). She saw these as valuable and essential to good practice. Her main role was in nursing, but she went to the maternity unit every year to maintain clinical hours however she did not feel this was adequate to achieve competency;

“I didn’t think I was up to par. Like, I didn’t think my skills were good enough.... I do try and go back each year to maintain my skills. Last time I felt a month really wasn’t enough.... If I felt I did something incompetent like if somebody got hurt as a consequence or not cared for properly that would be it, I wouldn’t go back, no that would be it. Time to concentrate on one thing (nursing)… so I hope I don’t ever get to that stage” (Naomi)

Nicole also identified difficulty with renewing her registration as a midwife. Her object was a photograph in which she discussed the importance of camaraderie of peer relationships. She talked about her efforts to maintain her midwifery skills, taking advantage of having a maternity service in the same hospital in which her role was a nursing one;

“...if our ward was closed, they would say go and help maternity.... I would probably do maybe six hours or something... it wasn’t a regular thing, you couldn’t predict it.... you’d get there and they would say great, you can have the nursery and you’d go in, get familiar with the babies and then the phone would go and they’d say you’ve had an admission you have to go back to your ward...”

She reflected on the organisational difficulties in her approach:

“...the biggest thing is not being supported by management, they complain they haven’t got midwives but when I am crying out to go there and get my practice hours up to date they say no we can’t let you go. And then the educator has kept me informed of courses
and when I have applied to go, the director of nursing has rung my manager and said, "What does she want to do that for?" (mimicking the conversation) "Cos she's a midwife!" "Oh. They don't seem to have any concept of what's going on in their hospital or who's who. So I just found it really frustrating and in the end and I thought this is ridiculous, I am just going to forget about it." (Nicole)

Nicole's narrative highlights the importance of a systems or organisational approach to supporting midwives to complete their CPD and maintain their competency. Despite her internal motivation and actions to undertake CPD lack of organisational support led Nicole to self-assess that she did not meet the requirements for recency of practice. She changed her registration status in 2012, to that of non-practising midwife.

Discussion

The aim of this paper was to investigate midwives' responses to the changed re-registration requirements in Australia, particularly decision making in regard to CPD activity. CPD ongoing professional development is recognised internationally as an important basis for a quality workforce and for the provision of safe and effective care (World Health Organisation, 2010). Findings revealed much about the motivation and thinking about practice that may be forming the basis of engagement with CPD in the face of the new regulatory environment. The participants' reflections on those aspects of their practice which they valued and which in turn, motivated their actions and ongoing professional development were given depth by the use of objects of value which they selected to discuss during the process of the interview.

Relationships with women were discussed by the participants and for some were linked to their decision making. Midwives were compelled to discuss the value of their relationships with women during discussion of their objects. It appears that these relationships encouraged them to engage in professional development. The appreciation women showed through expressions of thanks in gifts and cards provided confirmation of the difference the midwife made to their experience and so increased midwives' confidence in their ability to make a difference to women's experiences. Consequently this motivated them to continue to invest in their own self-development to improve care for women. Previous research has identified that meaningful relationships with women, where the midwife feels needed, are motivational and facilitate learning (O'Sullivan, 2006; Hunter, 2006; McCourt and Stevens, 2009).

Peer relationships were also identified as motivating. They provide aspirational exemplars in the form of role models. Participants' conversations suggested that the value of the experience of being mentored or mentoring others. Peer relationships were viewed with admiration and respect. Peer relationships previously discussed in the literature have highlighted issues such as lack of cohesion and lack of empathy among peers; research such as that by Deery (2003) reported stressed, demotivated midwives with no support within midwifery led teams and Ball et al. (2002) found that lack of support among peers was detrimental and demotivating.

In this study the majority of the participants' were dual registrants who planned to maintain both their nursing and midwifery registrations as they felt it was an obligatory requirement as an employee in an organisation relationship to meet service needs, especially in regional and rural locations. The decisions the majority of participants are making about their practice are based on self-evaluations of their clinical competencies and their aspirational plans. Self-assessment findings demonstrated the value of comprehensive practice competencies beyond the statutory CPD and recency of practice standards, for some participants there is a belief that they need to demonstrate recency of practice in all areas of midwifery practice; antenatal, intrapartum and postnatal areas. The Australian Nursing and Midwifery Council standards do not dictate that midwives must perform births. The National Competency Standards for the Midwife provide the detail of the skills, knowledge and attitudes required; 'It is expected that all midwives should be able to demonstrate that they are able to meet the competency standards relevant to the position they hold' (Australian Nursing and Midwifery Council, ANMCA, 2006, p. 4). This finding illuminates the tensions and links the decisions been made about CPD, practice and registration.

Conclusion

The novel practice situation in Australia, grounded in regulatory changes, potentially at least, has considerable significance for individuals but also for organisations and workforce planning more broadly. This study used objects of value in interviews, in order to assist in-depth reflection on issues surrounding practice competency and CPD. The findings that have emerged from the conversations indicate that midwives' motivation and the decisions that they make about CPD, registration and practice are based on implicit values and beliefs about practice. As a research sample, motivated individuals are commonly attracted to participate in research studies and so the reported decisions midwives are making about registration and future goals and aspirations are representative of the participant sample but cannot be presumed to be universally representative.

The findings revealed tensions concerning CPD and ongoing registration, born of self-assessment, particularly for registered midwives who are working in nursing positions where they are not required to use, regularly, their midwifery skills. Further, the findings provided insight into the need for system wide dialogue about ways to better acknowledge the challenges faced by dual registered nurses/midwives and to devise ways to support their ongoing professional development to maintain their competence and recency of practice. Facilitating opportunities for midwives to engage in meaningful relationships with women and their peers through team approaches has potential for beneficial outcomes. If individuals feel valued and supported they are more likely to be motivated to engage in CPD and maintain practice competency. Apprehending the reflections of individual practitioners at the forefront of this changed practice environment generates understanding of the relationships among motivation, CPD and registration renewal, which will in turn, inform workforce and professional development planning.

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Australian Nursing and Midwifery Council (ANMCA), 2006. National Competency Standards for the Midwife.


Publication II: Australian midwives’ interpretation the re-registration, recency of Practice standard.

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Australian midwives’ interpretation of the re-registration, recency of practice standard

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Abstract
Objective. The aim of the present study was to investigate how midwives are responding to the changed re-registration requirements; specifically the Recency of Practice (RoP) Standard.
Methods. A qualitative longitudinal case study used conversational interviews conducted annually at two time phases after the introduction of national registration.
Results. Findings reveal that confusion has created challenges in demonstration of the RoP standard. This confusion was evident at individual and organisational levels.
Conclusions. Professional bodies need to support staff in this transition by providing clearer guidance that exemplifies the Nursing and Midwifery Board of Australia expectations.

What is known about the topic? Impact subsequent to Australian legislative and regulatory changes affecting midwifery and nursing registration has not been examined.
What does this paper add? The findings of this study provide an insight into midwives’ responses to the changed re-registration standard in Australia.
What are the implications for practitioners? There appears to be a problem in the way tensions and challenges are being met; misinterpretation of the requirements has generated questions about the relationship between skills and work areas and demonstration of RoP. This may influence individual career planning and have broader workforce planning implications.

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Introduction
In Australia, the Health Practitioner Regulation National Law Act (2009)1 led to national registration in a bid to standardise the regulation for healthcare practitioners in Australia.2 The change to national legislation has led to a unified registration renewal process across 14 health boards in all states and territories of Australia. The national scheme has several objectives to keep the public safe by ensuring suitably trained practitioners are safe, competent and maintain competence to practice. The Australian Health Practitioner Regulatory Agency (AHPRA) registration standards include parallel requirements of continuing professional development (CPD), recency of practice (RoP) and insurance for practice across all professions. Separate national registers for nursing and midwifery were introduced in June 2010. The registration standard is designed to ensure that nurses and midwives have recent experience practicing their profession and that their nursing and midwifery skills are current and up to date.3 4

This standard requires that in order to re-register, a nurse or midwife must indicate that they have undertaken the equivalent of 3 months full-time practice in the last 5 years to demonstrate RoP in their profession. Practice is defined as:

any role whether remunerated or not, in which the individual uses their skills and knowledge as a nurse or midwife…practice is not restricted to the provision of direct clinical care. It also includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles…

These legislative changes have impacted registration for nurses and midwives, because the introduction of separate
registers has meant that nurses and midwives, for the first time, have been asked to demonstrate competency for registration on each register separately.

Despite the RoP standard forming part of the contemporary registration requirement, there is little literature examining the efficacy of this approach. Furthermore, requirements vary from country to country. Table 1 identifies variations in the requirements in comparable countries, such as New Zealand, Canada and the UK.

Prior to 2010 the requirements for registration of nurses and midwives in Australia were inconsistent across states and territories, making cross-jurisdictional movement difficult. Historically, nurse registration boards were originally introduced in each state between 1900 and 1926; in each state there was one register for nurses, with midwifery identified as an endorsement or certification. The introduction of separate registers for nurses and midwives in 2010 means dual registrants must now declare RoP for each register.

This paper presents findings from a study exploring Australian midwives’ responses to the re-registration requirements and insight into how the RoP standard has been interpreted by a sample of nursing and midwifery registrants since the change over the period 2010–13.

Methods

Recruitment of participants

A purposive sample of participants was recruited using a convenience recruitment approach. An advertisement was placed in the Australian College of Midwives News and invitations were distributed at midwifery conferences. Participants from five states (Queensland, New South Wales, Victoria, Western Australia and Tasmania) responded. A sample of 24 female participants aged 25–65 years was recruited into the study. Twenty of these participated in individual interviews and the remaining four took part in a focus group. Participants worked in a range of public and private health services and a variety of clinical, management and education roles. The size and diversity of the sample was sufficient to interrogate the case under consideration. Participants were able to provide their perspective on the introduction of the statutory requirements for national registration as it impacted their decision making about their future registration.

Ethics

Ethics approval for this study was granted by the University of the Sunshine Coast, Queensland on negligible risk (S/11/360). Participants were allocated pseudonyms and provided with information sheets and consent obtained.

Data collection

A longitudinal qualitative case study design was used with a two-phase data collection strategy to capture reflections and decision making of participants across two annual registration cycles. The strength of case study as a methodological approach lies in the flexibility of the methodology to facilitate the collection of a variety of data to provide an in-depth investigation. This single case study focused on the contemporary context: the initial years after the changed re-registration standards (2010–13). Data were sourced from multiple qualitative methods: individual interviews, objects, a focus group interview, field notes and registration renewal process documents. This paper refers to data from the interviews only.

Individual midwives’ experiences were collected in interviews conducted at two time points; the first time point occurred within the first registration cycle following the changes. The second interview was conducted at least 10 months after the first interview and within the second cycle of re-registration.

In Phase 1, an in-depth conversation style interview was conducted with 20 participants.

<table>
<thead>
<tr>
<th>Country</th>
<th>Registration renewal period</th>
<th>Requirement for RoP standard</th>
<th>Specific requirements to practice midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Annual</td>
<td>3 months in 5 years</td>
<td>3 months in 5 years</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Every 3 years</td>
<td>Must demonstrate practice across the scope of practice; antenatal, intrapartum and postnatal care up to 6 weeks</td>
<td>Annual registration certificate</td>
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<tr>
<td>Canada – British Columbia</td>
<td>Graduate midwives First 2 years</td>
<td>A minimum standard is set as follows: First 2 years: 40 women, 20 as principal midwife (10 in hospital, 10 out of hospital), 20 across the whole pregnancy, labour, birth and post-partum period; 60 women: 40 as principal midwife, 30 of the 60 in COC model, 5 in hospital, 5 out of hospital</td>
<td>Annual notification of intention to practice midwifery</td>
</tr>
<tr>
<td>UK</td>
<td>Every subsequent 5 years</td>
<td>Nursing and Midwifery Council does not specify the need to complete midwifery practice across all areas of midwifery practice, but states registrants must have 700 hours of practice across all areas of midwifery practice, but states registrants must have 700 hours of practice, 200 of which must be in midwifery</td>
<td>700 hours of practice, 200 of which must be in midwifery</td>
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<tr>
<td></td>
<td>Every 3 years</td>
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</table>
In Phase 2, follow-up interviews were conducted with 16 participants. The initial findings were presented for discussion at a focus group interview held in October 2013 with four midwives who had not been interviewed to verify the emergent themes. Furthermore, the collective perspectives of the focus group members were also gathered to record the impact the changes have had on them.

Analysis

All interviews were transcribed verbatim. Data were entered into NVivo (QSR International Pty Ltd, Melbourne, Australia), a computerised data management program used to manage large amounts of data and for coding text, generating early categories and creating themes from patterns. In the present study NVivo was used to manage the data and to generate initial codes. Analysis commenced in the first phase of data collection. An inductive coding process was used and continued within each interview and across interview transcripts. Analysis looked for repetition and pattern matching of issues within each phase and across findings of the two phases.

Rigour

Validity of the analysis process was ensured by asking participants to confirm authenticity of their transcribed conversations, via email. Rigour was established in several ways: (1) by participant checking of transcripts from interviews and participant authentication of initial themes in their second interview; (2) by ongoing verification of data and coding with research supervisors; and (3) by iteration and interrogation of the themes in the focus group interview. From this process, initial themes generated in each phase were compared with the final themes relating to the collective understandings held about RoP and the choices participants may make about re-registration.

Results

Findings from the present study indicated a strong preference for the national system in terms of portability of registrations. Participants who worked in areas where they considered both nursing and midwifery clinical skills were being used were clear about the RoP standard and able to articulate this. Narratives are illustrated using pseudonyms to protect the anonymity of the participants. Practice clarity was evident in participants in roles using dual registrations, such as Siobhan, working as a lecturer:

I have got reccency of practice in teaching midwifery and nursing so I can keep both...I guess it depends where you are practising (Siobhan)

Difficulties in meeting the RoP standard were experienced at individual, service and professional levels, and were articulated in discussions regarding skills-based activities, places of practice and patient type.

At an individual level, it is the way the practitioners interpreted the standard in a very narrow way and considered only the performance of direct clinical practice as constituting RoP. Natalie, a midwifery manager, explained her actions in response to her interpretation of what RoP meant to her:

Well I guess that means working clinically, so that is why I have gone back to the ward... (Natalie)

This was further articulated by Nell and Nicole, who both practised midwifery and explained how they would meet the RoP standard for nursing registration by identifying clinical skills linked directly to patient care. Nell, a midwife working in a postnatal ward, highlighted the ‘nursing’ skill component of her midwifery work:

...a lot of our day is made up of nursing skills...caring for IVs, evaluating wounds...so a lot of our role as midwives is nursing based. (Nell)

Rotations to other areas provided an opportunity to maintain RoP in both nursing and midwifery. Participants working as nurses identified that, historically, they had been able to rotate to maternity wards to maintain midwifery RoP:

...if our ward was closed, they would say go and help maternity... (Nicole)

Subsequently, concern was raised over their current situation, where midwives acknowledged that this opportunity had dwindled and the potential of not maintaining RoP hours in the future was real:

...when I asked to go back there, and work for a bit, I couldn’t because our ward was short of in-charge stuff. (Nicole)

Nicole, who worked full-time in a paediatric ward as a paediatric nurse felt she could not demonstrate 3 months RoP in midwifery over the last 5 years, even though she cared for neonates who had been re-admitted from home, after discharge from the maternity unit:

We have neonates but that was a bit of a grey area about could you count that or not? (Nicole)

Despite Nicole’s completion of continuing professional development hours for both registers, Nicole changed her midwifery registration to non-practising at her next registration renewal.

Evidently confusion existed around the RoP standard. The findings pointed to a limited understanding, where participants focused on direct clinical care and made little reference to the Nursing and Midwifery Board of Australia (NMBA) standard.

Confusion was not limited to clinicians. At service provider level, managers were reported to be confused. Sam, an antenatal clinical midwife, identified how her manager questioned her completion of RoP for nursing within her midwifery role. Sam’s response of disbelief over her manager’s comments is recorded here:

They [managers] are saying the terminology of direct patient care. I don’t do, because I am not hands on...I have to prove 20 hours of general nursing to keep my general registration but I deal with thyroid, cholestasis everything. You name it. Anaemia, yeah everyday. (Sam)

Uncertainty persisted at all levels. Inconsistent advice provided at a professional level from AHPRA was reported by Sandra, who recalled the advice she received was a deviation
from the NMBA standard on RoP. The following excerpt commences with her report of the question she was asked by AHPRA staff:

“When did you do your last shift? You have to have worked a shift...from what I had read, I did not think that was true, but that is what I was told. I was trying to get information from people who are supposed to know the rules, and so I ticked the box [not recent in midwifery].” (Sandra)

Sandra explained how her telephone triage position was not recognised by AHPRA as midwifery RoP:

“We do tele triage on anything to do with health...70% of the time we get mothers with young babies, miscarriage, you get a lot of women ring up miscarriage...so she needs anti-D because she has bled...there are many nurses that are non-midwives...they come to me and I use my midwifery [knowledge] all the time...they [AHPRA] will not count it because I am not employed as a midwife.” (Sandra)

Individual participants seeking clarification of re-registration requirements from AHPRA experienced difficulty accessing assistance by website and telephone:

“Every time they answer a question, it’s a hassle...It’s difficult to speak with someone if you are having problems with the online process...had to ring six or seven times to even speak to someone.” (Nancy)

Participants expressed frustration at the online registration questionnaire, suggesting it was very restrictive in relation to declaration of RoP and causing unnecessary stress for people. A consequence of the perception about RoP was an increase in requests received by managers for shifts to gain midwifery RoP experiences. These were not always able to be met due to workload and staff ratios.

“It’s part of my role to ensure where staff have identified that they need experience...that I give them the opportunity to rotate through, but I can’t...within the level of staffing that we have.” (Sharon)

Organisational imperatives and constructions of the RoP standard also impacted eight participants who questioned their need to maintain a registration they felt they were not using, but perceived organisational pressure to retain both registrations:

“I don’t want to be a nurse. I’d rather be a midwife but I don’t think I’m allowed to ditch my nursing registration and keep my midwifery registration.” (Sally)

Can I register as just a midwife? That’s something I have thought about. What do I do if I don’t have enough hours as a nurse? Does that mean I am not registered as a RN but registered as a midwife? Can they do that? I don’t know.” (Nenye)

Most participants perceived they had limited freedom to change their registration status due to contractual obligations.

Uncertainty existed over the professional ramifications of midwives relinquishing their nursing registration. In phase 2 interviews, participants in midwifery managerial positions were asked to reflect on comments made by other participants who had expressed a wish to become a single registrant.

“...they are hired as registered nurses and registered midwives...they can’t let their registrations lapse...we want staff who can work in all areas.” (Sharon)

The organisation does not want people to drop their dual registrations because when it is quiet they like to put a few extra patients in the ward [maternity] and if that happens they like to have general nurses to look after them.” (Zoe)

From a service perspective, dual-registered staff are desired for operational efficiency in all regions (rural, remote, suburban and metropolitan areas) because personnel can be mobilised at busy times to provide qualified carers for patients within the service structure.

Discussion

This research investigated midwives’ responses to changed re-registration requirements. Of particular interest, and perhaps concern, is the way that the RoP standard has been interpreted and the way ‘practice’ has been perceived by dual registrants, service organisations and AHPRA. RoP was mostly defined by participants in the context of the provision of direct clinical care. There was little discussion of the NMBA definition of practice, and the results suggest that in this sample there was limited understanding of how knowledge and skills can be used in a range of contexts, services and practice roles.

The NMBA ‘practice’ definition has clarified that practice is not restricted to the provision of direct clinical care; however, this was not the understanding of several participants in the present study. Many sought to gain clinical practice experiences believed they were needed to meet the RoP requirements for each register from their organisation, or even looked to other positions and facilities to meet what they perceived they needed. Dual registrants working in midwifery areas identified nursing practice hours within their existing role; however, three participants working in nursing environments (paediatrics, theatres and the cardiac care unit) sought midwifery practice outside their nursing environments. Uncertainty about what constitutes midwifery and nursing RoP impacted on the practice of individuals. Perplexed individuals with unresolved questions charged their registration status. Others attempted to justify RoP hours by articulating a dichotomy of nursing- or midwifery-specific practice skills-based activities for each register.

The latest NMBA annual report on registrations shows some indication of the impact of individuals changing registration patterns since the changes. In June 2011, the recorded total of dual registrants in Australia was 40,324. However, in March 2014 the total number of dual registrations had dropped to 30,278. The findings from the present study suggest that practitioners are making decisions to change their registration status. This change may be due to various factors. At service and professional levels, inconsistent interpretations have caused misunderstandings during registration. Even though the sample size in
the present study was not representative of the population, it does provide some insight into the issues that have been faced by practitioners that need to be further investigated and addressed.

Implication of findings

This research has uncovered issues related to the registration standard for RoP at individual, service and professional levels. Tensions and challenges are being encountered, and confusion over the requirements has generated questions about the relationship between scope of practice, work areas and their ability to practice as nurses and midwives. Concern has been raised about organisational pressures, which at times are at odds with individuals’ understandings of the standard requirements.

Recommendations

- Clarification of what is expected for RoP in nursing and midwifery practice is needed. This is work that could be undertaken by the Australian professional bodies.
- Improved communication regarding the RoP standard between Australian professional bodies and registrants and service providers by providing clearer guidance that exemplifies the NMBA expectations.
- Further research is required to build an evidence base around the relationships between recency of practice and competence.

Competing interests

None.

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23 Nursing and Midwifery Board of Australia. For nurses and midwives: News. Issue 1, March 2012. Australia: NMBA.
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Midwifery professionalisation and practice: Influences of the changed registration standards in Australia

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ABSTRACT

Background: In June 2010, the Australian Health Practitioner Agency unified the national registration of health professionals in Australia and introduced a separate register for midwives. Standard registration renewal requirements aimed to provide safe, competent practitioners. These new conditions created the impetus for practitioners to consider how they meet the re-registration standards for either their nurse or midwifery registers.

Question: How are midwives responding to the changed re-registration conditions for registration renewal?

Methods: Longitudinal case study design. A purposive sample of 24 midwives from five states was recruited. 20 took part in individual interviews over two re-registration periods. 4 midwives were interviewed in a focus group to verify the findings.

Findings: Three themes captured issues and tensions about registration and midwifery practice. They are Rotation, Restriction and Extension.

Conclusion: This paper has shown how the re-registration conditions and standards post-2010 have generated discourse around registration renewal. The simultaneous introduction of regulatory and legislative changes has resulted in the construction of categories within contemporary midwifery practice that do not necessarily align with the Nursing and Midwifery Board of Australia (NMBAA) requirements for re-registration. Further research is recommended to examine the continuing influence and impact of the changes on the Australian midwifery workforce.

1. Introduction

This paper reports the findings from a case study investigating midwives’ responses to the changed re-registration standards after the introduction of national registration in June 2010. It is aimed at providing empirical data that sheds light on the impact of the regulatory and legislative changes associated with the professionalisation of midwifery in Australia.

The principles of regulatory standards have changed little since their introduction with The Midwives Act in 1915. Historically, registration and regulation of nursing and midwifery in Australia has developed independently in each of the nine jurisdictions, including seven states and two territories. The lack of a national regulatory authority led to variations in conditions and standards across states and territories. For example, re-registration standards between states and territories varied. New South Wales (NSW) had no requirements for self-declaration of competence, no need for recency of practice declaration and no audit system; preferring to act on complaints made against practitioners. In comparison, Western Australia (WA) and Queensland (Qld) both had published guidance documents for self-review of competence. The differences continued; Qld had annual re-registration while WA gave practitioners the option of annual or triannual re-registration. Hence separate registration standards in each jurisdiction previously restricted cross-border workforce mobility. Plus, prior to 2010, when national registration was introduced, in some regions midwifery registration was an endorsement or certification on the nurse register, and non-nurse midwives were registered as nurses with restrictions to only practise midwifery. This situation impacted on projections of future workforce planning and also influenced the shape, practice options and direction of midwifery in Australia.

Over the years Australian midwives have standardised professional registration requirements and been vocal about their
development as a separate profession, seeing professionalisation as a key to delivering high quality, safe maternity care. They have been instrumental in advocating for numerous reviews of maternity services, engaging consumers, regulatory authorities and policy makers. Their efforts helped inform strategies for the National Maternity Services Action Plan8 and in 2006, the Council of Australian Governments (COAG)9 agreed to establish a single national registration and accreditation scheme for health professionals. The Health Practitioner Regulation National Law Act10 was the driver for change towards the adoption of a national registration and accreditation scheme for health practitioners. Thus the Australian Health Practitioner Regulatory Agency (AHPRA) was instituted in July 2010.

1.1. Regulatory changes

The National Registration and Accreditation Scheme (NRAS) was intended to keep the public safe through the development of a flexible, responsive and sustainable Australian health workforce that is suitably trained and qualified. The scheme was also remarkable in bringing about national uniformity of standards across health professionals. In this respect, Australia has led the way internationally, being the first country to exemplify a regulatory model that incorporates all licensed health professionals including medical and allied health disciplines.

The new regulatory model introduced separate nursing and midwifery registers. The change from the previous combined register was accompanied by uniform specification of standards, particularly with regard to Recency of Practice (ROP)11 and Continuing Practice Development (CPD)12/13 and insurance cover to be met for annual re-registration on each register. Practitioners are now able to register on one or both of the registers. This condition created the impetus for practitioners to consider how they meet the re-registration standards on either register.

1.2. Simultaneous legislative changes

A number of simultaneous legislative changes have impacted on the way midwifery could be practised in Australia. Changes to Medicare Benefit Scheme and Pharmaceutical Benefit Scheme now allow midwives to provide women with rebates for private midwifery services. In addition, the new regulatory standards introduced the option of an endorsement on the register as an eligible midwife.14 Eligibility status is granted to midwives who have current registration as a midwife with no restrictions on practice, and authentication from a credentialing process15 that the midwife has three years full-time experience, and current competence across the full scope of midwifery practice. This endorsement attracts further requirements at re-registration in that an additional 20 hours of CPD must be completed annually.16 Eligibility endorsement afford new opportunities for midwives to develop service choices previously not available in Australia and extend their practice, for example to gain visitation rights to hospitals.17 These changed conditions in which simultaneous regulatory and legislative standards were introduced have had implications for midwives in that the new conditions have presented an opportunity for practitioners to reflect and examine their professional positions, and future plans in terms of service type and role. Midwives have done this within the context of the National Maternity Service Provision models available in Australia.

1.3. Maternity services in Australia

Maternity care in Australia occurs in a range of settings. Women can access care through public or private maternity services. In the public sector, options of different models of care are open to women depending on location. Rural/remote services are often provided by small units where services are accommodated within the same building or in the community setting. Frequently, women have to travel to larger hospitals to birth. In comparison, suburban and city hospitals offer extended options for maternity care dependent on the acuity of the woman’s condition. Examples of common public maternity service provision include: shared-care between the women’s General Practitioner and the hospital, midwife-led models of care, or obstetrician-led care. Depending on the model of services provided, care can be delivered in or out of hospital. In Australia private maternity care has been provided either by obstetricians in private hospitals or independent private practice midwives in women’s homes.

The National Maternity Services Plan 2010–20158 and the National Maternity Services Capability Framework13 both made recommendations for public and private maternity services to move towards more woman-centred services, in as many localities as possible across Australia. The national maternity services review report recommendations rest on principles that care should be based on the best affordable evidence, aligned with legal, regulatory and professional standards with objectives for care focused on safety, quality, planning and coordination.4 Regulatory and legislative changes were intended to benefit women by increasing their options in maternity care services.5 Recommendations of the plan have impacted on maternity services by becoming key strategic benchmarks.

To date there has been limited research regarding the implications of these changes for practitioners on the way that regulation and legislation might impact on them, their profession and their practice.

1.4. The research question

The purpose of this study was to address the question, “How are midwives responding to the changed conditions for re-registration to practice in Australia?” In particular, how midwives are negotiating the tensions between opportunities and challenges presented by the current requirements? This paper reports on the impact of regulatory changes on midwifery professionalisation.

2. Methods

A longitudinal case study design16 was used, to facilitate an in-depth examination of midwives’ decisions and strategies over two and half years (October 2010–June 2013) and to coincide with the initial two annual re-registration windows immediately following the regulatory changes.

Ethical approval for this study was granted on negligible risk (S/ 11/360). All participants voluntarily agreed to participate in this study and in accordance with ethical standards written informed consent were obtained from each participant. Pseudonyms are used to present the findings.

2.1. Participants and recruitment

A purposive convenience sample17,18 of participants was recruited from the Australian states of Queensland (Qld), Western Australia (WA), New South Wales (NSW), Victoria (Vic) and Tasmania. The participants were registered midwives and at the time of their recruitment which was in the first registration cycle following the transfer to national registration and the creation of separate registers for nurses and midwives, all but one of the participants was registered on both registers (see Table 1).19 Twenty midwives were from four states were recruited via advertisements in professional journals and conferences to take part in individual interviews. A further four participants from a 5th
<table>
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* Each name is a pseudonym to protect anonymity.
RM/RN = first designated registration denotes the participants' perceived primary role.
state were recruited via a snowballing approach to take part in a focus group. Participants worked in diverse settings, including education, management, nursing, and midwifery clinical practice. Table 1 details information about participants.

2.2. Data collection

Data were collected in 2 phases. In phase 1, in-depth, individual, conversational interviews were held (October 2011–May 2012) with 20 participants who were again interviewed in phase 2 (August 2012–April 2013). At the initial interview, participants were invited to respond to a statement that outlined the changes to the re-registration requirements after the introduction of national registration in 2010. All interviews were digitally recorded and transcribed verbatim and transcripts of individual interviews were then sent to interviewees, for verification. In addition, a further 4 midwives took part in a focus group interview in June 2013 to discuss and verify the initial themes that were generated.

2.3. Analysis

Thematic analysis took place throughout data collection. Categories were constructed through an inductive coding process,20,23 which involved looking for iterations of similarities, comparisons, repetition and pattern matching of data. Confirmation of the categories that developed from the process was agreed between the research team. Field notes were used to catalogue the evolution of themes providing an audit trail of decision making to increase credibility.19

The following reports the findings that identify midwives’ response to the introduction of statutory re-registration requirements in the initial years after national registration commenced.

3. Findings

The participants reflected on how they would meet the re-registration standards, particularly the RoP standard, to maintain their registration as midwives and/or nurses. They described their decisions within the familiar boundaries of service, role and type of work. They reflected within the parameters of a childbearing woman’s continuum through pregnancy, birth, and postnatal experience, which also broadly reflects the construction of mainstream maternity services in Australia, in both the public and private sectors. The findings reveal a range of constructs which influenced individual participants’ decision-making about their future registration and where they would or should practise. The findings also reveal underlying constructs about contemporary midwifery in Australia and the essence of attributes/qualities/values perceived as necessary to achieve a commonly shared image of someone who meets the requisites of a complete midwife. Three themes were generated from this analysis, which capture issues and tensions about registration and midwifery practice. They are:

1. Rotation
2. Restriction
3. Extension

3.1. Rotation

Rotation captures an aspect of a majority of the participants’ narratives in which they identified the need to meet the RoP standard in midwifery by demonstrating practice in each or even all areas of a maternity service; in antenatal clinics, antenatal and postnatal wards and birth suites. Some talked about this in terms of service locations/areas and others talked about it using the language of the childbirth continuum through antenatal, intrapartum and postnatal. They used this schema to assess and compare their competence and ability to meet the re-registration standard. Sharon aged 54 years had been a midwife for thirty-one years. She worked as a clinical manager in a busy tertiary maternity service which provided antenatal, intrapartum, postnatal, neonatal and community outreach services in specific clinical units. Sharon provided some insight into her beliefs about midwifery practice as she explained the maternity service provision in relation to the RoP standard from her perspective as a manager:

‘...we want staff who can work in all areas...’

Sharon assigned importance to the ability of staff to maintain their skills and be competent, and to facilitate staff members’ identified needs, through the process of rotation around units within the service;

‘...it’s part of my role to ensure that staff have identified that they need experience, that I give them the opportunity to rotate through... if I’m looking at clinical staff... somebody in birth suite I would have to say for me they should have been maintaining their skills.’

Clinical skill competence in each of the units was considered important, and Sharon herself planned to rotate to other areas of the maternity service to refresh and maintain her own clinical skill.

‘...as for maintaining skills I practise regularly in the birth unit, I plan to do a shift rotation next month... to refresh and maintain my skills... it’s important to me for recency [of practice] to be able to do those things... [can midwifery]’

In her narrative, Sharon’s behaviour to maintain her clinical skills and provide her peers by role modelling examples of expected behaviour.

‘obviously in a managerial role or a leadership role your practice is being able to do all the things that are required of that role... it’s also maintaining my skills so I could support the staff on the floor if they needed something done’

Sharon identified the value of a workforce who could be mobilised and importantly, the ability to care for a woman at any stage of pregnancy, childbirth and puerperium, that is.

“We do this because we want staff who can work in all areas. So if birth-suite goes pear-shaped we can pull someone off another area... setting aside what a midwife is... the only position legislatively you have to be a midwife in is birth-suite’

Other participants who were also in clinical service management positions also shared this view.

Sharon’s construction of the need to rotate to all areas of the maternity services was used as an important measure in assessing staff members’ competence to claim RoP. In particular, the birth suite was held as a pivotal place in a hierarchy of importance, in the rotation of staff and their need to demonstrate competence. The significance of birth suite was further illuminated by references from participants to their perceived need to rotate from other areas of the maternity services.

Sally, 34 years old, unlike Sharon was not a manager but had practised midwifery full time for the last four years. The expanse of her midwifery experience covered team midwifery, birth suite, postnatal ward, antenatal care and education, neonatal intensive care, and home visiting services. At the time of her first interview, she practised in a remote region providing community antenatal
and postnatal services. The following narrative expresses her confusion and personal construction of the RoP requirements:

‘...recency of practice? No idea, correct me cos I’ll probably be wrong but I thought it was 5 births per year’

Sally’s perception of the need to demonstrate experience in all areas of midwifery practice was illustrated in her explanation of what she did to ensure she met the standard;

‘...[I] went to the nearest hospital to gain birth suite experience... to the hospital to get five births.’

Sally already worked in community providing antenatal and postnatal care to women, but her perception of the need to work in or rotate through all areas of the maternity services illustrated her understanding of the requirements to demonstrate competence of RoP for re-registration. Working all areas and rotating was a common theme but restrictions also emerged as set out in the next theme.

3.2 Restriction

This theme concerns a number of restrictions on participants’ ability to meet re-registration standards. Restrictions limited their practice in some way; either by restricted access to certain service locations, types of activities or limitations inflicted by role or contracts status. As rotation was defined by access across boundaries of the childbearing woman’s continuum through pregnancy, birth, and postnatal experience limited access was thematised as restriction both in and out of the hospital.

Sue, in her mid-fifties, had been a midwife for the past 15 years. Her initial midwifery practice had been hospital based within a neonatal intensive care unit. In her current practice, Sue now worked part-time as an independent private practice midwife in two chemists in a suburban community, where she provides postnatal services to mothers and their babies. In this role she felt her practice place was unconventional, as it was outside mainstream midwifery services; Sue felt her practice location limited her ability to meet the requirements for RoP.

‘I am still practising as a midwife, even though it’s in private practice enterprise... not within a hospital setting...[however] I have tried to work out where I fit into the grand scheme of things not being employed in a hospital... you feel like you’re out of touch if you don’t work in a hospital setting’ (Sue).

Tension existed about practice location this was further highlighted in the way she constructed her reflections, and her language choice, as she discussed her lack of recent birth suite experience and how this was problematic for her:

‘As a non-practising birth attendant... I don’t feel like I would qualify as a registered midwife... I haven’t done that many deliveries since my training... I don’t want to go and deliver babies in people’s houses... I would feel really nervous going back into a delivery suite’

Sue’s description of herself as a non-practising birth attendant was an interesting choice of phrase, which she qualified by indicating she felt she would not be competent to birth women. Her concerns about competence to re-register as a midwife, involved a perception of limited practice, and lack of access to RoP in birth suite, which created tension in relation to her ability to demonstrate competence as a midwife. Sue’s narrative implied that she felt she needed to practise births, and she needed to access a hospital birth suite to bring this aspect of her practice up-to-date.

To refresh her practice, Sue attended an interview at the hospital to seek shifts in order to access birth suite experience. However, Sue was met with apprehension and doubt about her midwifery practice abilities; Sue reported:

‘...it was really deflating. I was demoralised by the whole thing... they weren’t nasty or anything... But they sort of said. “You’re doing what?”’ (Sue)

The reaction of panel members created doubt and tension for Sue in constructing her professional role as a practising midwife or non-practising birth attendant. She expressed;

‘...if you don’t fit into a hospital criteria it’s really difficult to be acknowledged as a professional.’ (Sue)

Consequently, despite being offered casual work in the hospital Sue declined the offer, unconvinced that she would be facilitated access to practice within birth suite. So with her perceived limited access she remained in her community location to await the outcome of the next registration cycle. Other participants within casual and part-time positions also expressed tension in regards to perceived restrictions to their specific practices, role or service location.

Eve, who was in her mid-forties, had been a midwife for four years. She described her midwifery training as limiting because she trained in a private hospital where she felt the obstetricians obstructed her opportunities to practise to her full potential. Since graduating she had worked casual shifts in a maternity service at a public tertiary hospital to fit around her family commitments; three children of school age. Eve worked casual shifts to fit around her husband’s roster. However, having the constraint of casual employment prevented her from practising to her full potential;

‘Probably one of the areas I am finding that I am not doing very well is antenatal because I don’t do the antenatal clinic. I just do the monitoring of the antenatal patient (in the ward). ... I am aware that they want you to be what I call a whole and complete midwife and work in all areas. It is important that I look at those areas and don’t let them get too far behind’

Eve’s narrative raised a few issues. First Eve provided care to antenatal women on the ward as in-patients, a practice which she viewed as doubtful because she felt this did not reflect midwifery-led practice. She also perceived that her practice was limited, as the care of well-women in midwifery-led antenatal clinics eluded her as a casual employee. This was problematic for her because she felt she needed to become a complete midwife who ‘works in all areas’. Furthermore, this was rarely birth suite; a place she felt she needed more practice. Hence, birth suite was her next concern;

‘I often do a lot of night duty, which is fantastic because you do get to ‘work in all those areas’... in birth suite. Some of the maturer staff, we shall call them, think because I am casual I can’t work in birth suite...’

Consequently, Eve’s access to intrapartum care was seen as limited by a number of factors; her contractual agreement was her biggest issue that impacted on her access to rotation. This then led to a secondary restriction based on who was on duty that shift, and how they perceived her status, and finally Eve’s life situation further inhibited how she could practise. Therefore, the combination of work and family factors influenced how Eve perceived she could complete the RoP standard.

‘I am having to pay for before and after school care. I do have a husband but he works full time, and is away with the mines’. Later, at the follow-up interview Eve’s situation had improved; her husband’s work commitments had changed meaning he was able to assist in caring for their children. This supported Eve to seek
work she believed enabled as 'practice in all areas'. Eve planned to seek work experience elsewhere:

‘...I am now considering going up north. I am trying to get a little day time birth-suite experience... they are desperately looking for people to fill some rural placements.’

In effect, Eve is saying that she perceived her hospital site to be limiting her practice and access to both antenatal and intrapartum practice, hence she sought midwifery experience elsewhere. Her ideological belief of woman-centred care and ability to provide care across the continuum influenced how she and other participants considered whether they met the RoP standard or not.

3.3. Extension

The two themes above demonstrate tensions in the way participants constructed their understandings about their practice adequacy across ambiguous, yet idealised, areas of midwifery practice. Their concerns revolved around the types of work and the types and range of services they had access to, across the childbearing continuum and reflected the mainstream organisation of maternity services in Australia. A further theme was also present. Extension. In this theme the value of practising across all areas is maintained but it also captures an idealised understanding of midwifery as well as capturing the work of a number of participants to practice differently and be involved in different types of services, extending their experience. A key focus of these narratives was on private, independent practice and eligibility endorsement. Achieving or working towards meeting the requirements for this service type and practice environment was important for some of the participants. They expressed a need to extend themselves and their practice skills and knowledge.

The following 2 narratives exemplify this theme.

Nancy

Nancy’s narrative reflects the aspiration of extension. She originated from New Zealand and had been qualified as a midwife in Australia for one year at the time of her first interview. She worked full time as an agency midwife in a remote base-hospital with a maternity service, where her normal working week involved providing care to antenatal, postnatal and birthing women within the same unit. She appreciated this organisation of the service and described how the physical containment of the unit enabled her to practice ‘across all areas’.

‘It’s a 8 bedded ward with a birth suite on the end of it so on a normal shift you might have birth-suite but you might have antenatal patients, on another day you might just have postnatal patients’.

Nancy practised midwifery caring mainly for women who fitted the health service criteria of 'low risk' suitable for midwifery care. She easily practised across the woman’s childbearing continuum in this setting, without the need to rotate. Nancy reported that this way of working fitted her philosophy, and contributed to her preparation for her future career goal of independent practice;

‘...that’s the way I like to do midwifery, be with women, to be natural and go with the body... I want to go home and become an independent practitioner... It’s my dream job, being a midwife.’

With a desire for independent practice, and her focus on the sustained relationship with women at the heart of her idealised practice, this environment enabled her to meet her aspirations to practise across all areas of the childbearing continuum ready for an independent midwife.

Simone, aged 37 years old and a mother of three children, originally registered as a midwife in Europe in 1997. Simone had practised as a private midwife in her home country and New Zealand before moving to Australia. Again, ‘working in all areas’ was flagged as an important part of her practice:

‘...we had access to one hospital which we had an access agreement with, and we also supported home birth... then I went for two years to New Zealand. Initially I worked in a case loading model... we worked autonomously for the antenatal, intrapartum, postnatal care...’

The legislative and regulatory changes in 2010 meant that in order for Simone to practise as an IPPM she needed to meet new practice standards. Simone explained how she went about that:

‘...for me personally I obviously prioritised what I had to do to achieve eligibility so for my CPD requirements... one part that I liked was the MPR which is the Midwifery Practice Review... I didn’t find it was a huge challenge...’

At the time of her initial interview in 2011–12, Simone was working part-time as an independent private practice midwife (IPPM) and part-time at a suburban hospital. However, she was also involved in project work to organise access for IPPM to the hospital, thus visitait rights would extend her practice.

‘At the moment I am seconded for project work which is 0.7 but normally I am 0.4 and approximately 0.5 as an independent midwife’.

The project work involved a working party to establish the details of visiting rights for independent midwives to the public hospital she was contracted to. The following excerpt from Simone’s transcript again raises the implied importance of practice ‘in all areas of midwifery’, but in this instance it was to gain recognition through the Midwifery Practice Review (MPR) process to meet the requirements of the professional body in order to maintain eligibility status;

‘Obviously you have to prove you have sufficient midwifery experience ‘in all areas’ of midwifery... it’s not sufficient to prove you have three years equivalent of full time midwifery practice... you have to prove you have worked across the continuum of midwifery care... antenatal, intrapartum and postnatal yeah.’

Simone extended her registration with the eligibility endorsement and developed her practice from how it was before the introduction of regulatory changes in June 2010.

These narratives were selected as examples to illustrate the themes that were constructed from the data. Participants’ perceived need to ‘work in all areas’ of the maternity services was universal and expressed as the provision of midwifery care across the continuum of pregnancy, birth and postnatal period. With rotation, as a theme, issues with access to areas in maternity services that facilitated specific practices were constructed as restrictions and, as such, problematic for a number of participants. Participants in this sample able to achieve midwifery practice in all areas did not express any issue with meeting the RoP standard and were confident they met the re-registration requirements. With the introduction of new legislative and regulatory conditions, seven participants were working towards developing or extending their scope of practice to achieve eligibility endorsement on the register. At the start of this study 2 midwives held eligibility endorsement. By the end of the study; there were three eligible midwives in the sample. New roles and service types provide women with greater choice as mainstream options.
4. Discussion

This research aimed to examine midwives’ responses to the changed registration environment after the introduction of national registration and statutory requirements for registration renewal in Australia in 2010. The language of rotation, restriction and extension framed the participants’ reflections on the requirements for re-registration and their decision making regarding their registration and practice. The findings also reveal perceptions about what it is to be a midwife and midwifery practice, which contribute to contemporary discourse about the profession.

The themes capture the importance of place as a way participants’ defined boundaries or parameters of their practice and re-registration considerations. Place locations were used as both a backdrop, but also a frame of reference; for example, the practice place parameters were used to define what activities occurred in that place to demonstrate their competence for RoP. Not surprisingly, this thinking reflected the organisation of maternity services within which participants practised. In a study of midwifery practice in different birthing environments, Bourgault et al. argued that place as a site of performance carries symbolic importance as a site of meaning making and identity construction created by the ways in which it is used by the people within it (p. 583). The relationship between place and the construction of meaning and identity as described by Bourgault is also reflected in the findings of the present study. The relationship between where participants practised, what they practised and how they constructed their identity as midwives was apparent. In this study participants suggested they needed to rotate or to access all areas of the maternity services in order to demonstrate RoP and by being able to do they then made links to their practice and identity as midwives.

While the ability to access all areas of maternity services and by default practice with women across the childbirth continuum was the central issue/focus this sits at odds with the NMBA requirements. While this construction was important to them it does not align with re-registration requirements, in that the NMBA does not require midwives to practise across the continuum of care during pregnancy, birth and the puerperium to demonstrate RoP. Nevertheless, the theme restriction reflects participants’ interpretation of the re-registration requirements as they identified, that for a range of reasons, it would be difficult for them to meet RoP and consequently their re-registration. The common restriction involved an inability to attend births. This perception was shared by both practitioners in community settings who were not attending births and those in hospital settings who were not rotating regularly into birth-suite. They effectively questioned their legitimacy as midwives based on their limited access. This construction led to at least one participant changing their registration status. Participants decision making around different aspects of practice illuminated participants’ constructions, upon which the status of their competence as a midwife’s is judged.

The third theme, Extension, also reflected the need to practice in all areas, but there was an added dimension in the discourse of some participants. For these participants independence, private practice and eligibility represented essential identity construction and legitimacy to fulfil the principle of ‘being with women’ and expand the available services for women.

The participants in this study constructed the essentials of RoP in different ways. However, attending birth and ‘being with woman’ were activities regarded as exemplary practices that represented a rhetoric of completeness and reflected legitimacy as a midwife. The rhetoric around completeness as a midwife and its relationship with place of practice and the work of attending birth was central to fulfilling the definition of a midwife and the scope of practice across all remits of midwifery practice. Thus, in this study, birth suite provided uncontentious identification of midwifery practice, as birth suite was isolated as ‘the only true place of a midwife’. Their narratives of being the ‘complete midwife’ or the ‘best midwife’ reflected personal constructions about how participants saw their midwifery professional practice aspirations and captured the essence of an imperative to meet a contemporary and explicit professional midwifery agenda around woman-centred practice.

The symbolic constructions of identity reflected in the findings not only reveal what individuals may be thinking and doing, but also the dynamic production and re-production of the midwifery profession. They reflect a process of professionalisation in which categories define and locate professional legitimacy, or alternatively exclude certain practice. Processes of categorisation revealed in the findings are based on issues with practice roles and activities which were associated with particular services and places and which illuminate how some categories of practice can be legitimised while others are excluded and lose legitimacy. Categorisation of midwifery has previously been alluded to. Taylor collated and characterised submissions from the profession in response to the 2009 Australian National Maternity Services Review. She discussed two categories: one category, independent midwifery reflected submissions with an emphasis on promoting birth outside hospital environments and within private practice. In the second category, ‘public health midwifery’, Taylor argued for extending midwifery led services, but within the public sector. Essentially, Taylor suggested that while the two categories appear opposed in their constructs of legitimacy in the profession, they have common ground – autonomy, the provision of ‘specialist services’ in normal birth and an emphasis on continuity of care, but that the public health category was more representative, better engaged in dialogue, and better positioned as integral to democratic professionalisation.

Furthermore, subsequent developments have led to public health midwifery characteristics legitimised in government and professional guidance documents. The tendency to define categories within the midwifery profession is contentious, but not new. In an earlier Australian study Lane reported the characteristics of her research participants as the obstetric assistant, autonomous midwives and the hybrid midwife, concluding that midwifery is ‘fluid and subject to changes over time according to age; experience; and setting of practice (private or public hospital, birth centre or home). Lane saw the hybrid midwife as a multipurpose practitioner with similar characteristics to Taylor’s ‘public health whose strength is an ability to work legitimately within the maternity system services. Both Taylor and Lane identified forms of categorisation within the profession of midwifery based on practice activities and place of practice.

The findings of the current study suggest that professionalisation through categorisation and birth attendant legitimisation discourse continues to occupy attention in midwifery and may be key drivers with the potential to shape institutional change. The collective discourse around the uncertainty triggered by the introduction of the 2010 re-registration standard appears to have led to the foregrounding of normative values around what is acceptable demonstration of competence and currency of practice based on perceptions of legitimacy and completeness. Soddaby and Vialle have explained that it is not uncommon for professions to interpret ‘dictates of government’ and respond by creating new processes which introduce new categories, procedures and hierarchies that become accepted within fields and adopted as ‘legitimate’ expectations within the group. Midwives’ decision making about their registration has foregrounded particular aspects of midwifery practice and the profession. Service provision drivers determine institutional changes and the types of services provided by midwives for women and their families. In shaping
institutional change, if the discourse of midwives impacts on their practice and the services then it is assumed that it will also impact on women and potentially the services available for them.

4.1. Limitations

The nature of qualitative research means participants construct meaningful reality in response to their situation at the time of the investigation, so hence, if data were collected again from the same participants, different perspectives are possible, as this study was performed during the years immediately following the introduction of the national standards. The findings are not reported as generalisable to the greater population however elements of the findings may be transferable in particular situations, particularly given the breadth of the sampling frame across several states.

5. Conclusion

This paper has shown how new standards have led the way to generate discourse around registration renewal. The findings have suggested that rhetoric has led to the construction of categories of midwifery practice that don’t necessarily align with the NMBA requirements and subsequent re-registration. Furthermore, the reflections on practice in ‘all areas’ also do not reflect the current provision of the majority of maternity services in Australia. Discourse foregrounds perceived categories of midwifery practice and has identified triggers that may potentially influence midwives to re-register decisions and thus shape services in the future.

Further research is recommended to examine the continuing influence and impact of the simultaneous regulatory and legislative changes on the Australian midwifery workforce. Of particular interest are subgroups within midwifery. As midwives practice in different ways and different locations, further research is required to continue the study of the evolution of subgroups within the midwifery profession. There is a need to examine consequences of discourse to change and shape maternity services and choices available to childbearing women and the roles of midwives.

Conflict of interest

There is no conflict of interest for the authors.

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Chapter 6
Discussion and Conclusion

The aim of this research was to investigate midwives’ responses to the changed conditions of registration renewal following the introduction of national registration and statutory registration renewal standards, which introduced options for midwives in Australia. These findings are novel in that this is the first qualitative evidence of midwives’ responses to this distinct and significant change period. In the post 2010 registration context where separate midwifery and nursing registers exist, a changed professional landscape has emerged. For the first time since 1928 midwifery registration is regulated independently from nursing. Registration renewal standards must be met for each register, with some overlap permitted.

The findings from this study captured midwives’ perspectives during the initial two years of national registration renewal (2010-2012). The findings reflect the transition period as one with a lack of clarity and confusion in regards to the changed conditions of registration-renewal. Conversations about the new registration renewal standards captured midwives’ perspectives as they reflected on their current and future career trajectory in an environment of changing maternity service provision. The midwifery register now includes an option of an endorsement for eligibility status. This option was not available before 2010 and this has also factored in the decisions midwives made about their registration and their ongoing future career plans.

The three publications presented in Chapter 5 capture the key findings from this research study to present the perspectives of midwives and identify a number of factors that influenced their decision-making as they responded to the changes. The first two papers illuminated the participants’ reflections on their roles, and practice; whether in nursing or midwifery services. Paper 1 (Gray et al, 2014) reported on what was found to motivate midwives’ decision-making in relation to meeting registration-renewal standards. Paper 2 (Gray et al, 2015) illustrated the decisions made at the time, and reflects uncertainties and tensions over how RoP could be demonstrated for each register. Novel aspects of practice emerged, around completion of everyday practice in different roles, health services, clinical
activities, and types of patients. Issues arose from midwives’ interpretation of how they defined nursing and midwifery in ways which influenced their decisions.

Paper 3 (Gray et al, 2016) further interrogated the issue of professional identity and provided insight into changing professional representations of midwifery. Professional influences were seen to impact on how these midwives responded to the changed registration-renewal conditions. Themes of rotation, restriction and extension reflect how participants in this study saw themselves and identified within the professions of nursing and midwifery. Dichotomising professional identities as a nurse or midwife became apparent through the use of boundary settings around RoP.

In this chapter the findings are discussed briefly through the lens of professional identity as they confirm and extend existing knowledge. The findings suggested an emerging and idealised professional identity concerning completeness as a midwife. Recommendations for practice and further research suggested by the findings are set out.

**Boundary setting, validation and identity**

The findings from this study particularly those discussed in paper 3 (Gray et al, 2016) concern professional identity, and the thinking and values that contribute to the construction of contemporary midwifery identity. A useful lens through which the findings can further be explained is self-categorisation theory (Hogg & Terry 2000; Terry & Hogg, 2001; Suddaby & Viale, 2011). As introduced in Paper 3 (Gray et al, 2016) the theory of categorisation, explains how professionals define values that determine what validates practice (Suddaby & Viale, 2011; Terry & Hogg, 2001). Features of the self-categorisation theory describe and prescribe attitudes of group members (Hogg & Terry 2000) and the likelihood of individuals to respond in predictable ways determined by the expected behaviours of their group. Individual and group perspectives categorise the most noticeable determinants of practice that signify legitimacy of the social actors within the field (Suddaby & Viale, 2011). In this study a situation resulted where participants separated and contrasted aspects of their practice as nursing or midwifery or both, a process of identification and validation. Relationships with women, their perceptions of the midwifery profession, and the way they engaged in the provision of maternity services illustrates this point. These influences are important aspects of self-categorisation theory and show ways in which midwives validated their identity for
registration renewal by setting boundaries to signify differences in their registrations, and exaggerated characteristics by illuminating similarities and inconsistencies. Of note and unexpectedly what CPD might be needed or undertaken did not play a significant part in these constructions.

Findings suggested perceptions, values, beliefs, and behaviours that define differences between nurse and midwife practices. Figure 3 illustrates this point in a continuum diagram using examples provided by participants. Place, activity or practice, and types of patients or clients were identifiers revealing perceptions of the participants about their own practice but also their professional identity (and by association the professions more broadly) as nursing or midwifery or a combination. These identifiers were also reflections of competency as nurse or midwife when considering registration renewal.

<table>
<thead>
<tr>
<th>Category</th>
<th>Clearly nursing</th>
<th>Practice overlap</th>
<th>Clearly midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Places</td>
<td>Theatres</td>
<td>Neonatal unit</td>
<td>Birth suite</td>
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<td></td>
<td>Medical</td>
<td>Community</td>
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<td></td>
<td>Surgical</td>
<td>Antenatal clinic</td>
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<td>Activities</td>
<td>Paediatrics</td>
<td>Breastfeeding</td>
<td>Postnatal ward</td>
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<td></td>
<td>Care of wounds, intravenous</td>
<td>Tube feeding</td>
<td>Births</td>
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<td>infusions, catheters</td>
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<tr>
<td>Patients</td>
<td>Ill, unwell infants</td>
<td>Cannulisation</td>
<td>Postnatal Care</td>
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<td>Women after caesarean section</td>
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<td>Well infants</td>
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<td></td>
<td>Men</td>
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<td>Pregnant women</td>
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<td>Sick people</td>
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<td>with ruptured membranes</td>
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Figure 3

*Midwifery nursing identification Continuum*
In the findings the type of person being cared for was illuminated as significant in determining evidence for meeting the RoP standards. Women and their babies who were well, were unmistakably within the scope of midwifery practice thus included on one end of the continuum and emphasize midwifery specific practice. At the other end of the continuum is the care for patients of any gender and any age group, but specifically the sick, these types identify nursing practice but not midwifery practice.

The service and setting identified in the findings also function as symbolic boundaries. Nursing wards are clearly located at one end of the continuum. Interestingly, community based services, neonatal nurseries and even antenatal clinics appear in the middle of the figure, signifying the reflection that they were not clearly located as places where current practice competence in midwifery would be recognised and where RoP for midwifery might not be validated. Birth suite represents a boundary. It can be argued from the findings that without working in birth suite and the practice of attending births, validation of midwifery practice may be uncertain or incomplete. The continuum further represents the findings set out in Paper 3 (Gray et al, 2016), practising across all areas – a way of boundary crossing, validating midwifery practice and identity.

The findings of the current study suggest that separate identities were validated by constructing symbolic boundaries in practice. They were effectively markers of role identity involving rules of inclusion and exclusion (Montgomery & Oliver, 2007). These served to categorise differences and similarities between professions and thus registration options.

The perceived differences between nursing and midwifery practice while in some ways stereotypical were accentuated or exaggerated, as the most salient characteristics were portrayed (Hogg, Terry, White 1995). Collectively practice attributes characterize group members and distinguish them from other groups (Hogg & Terry 2000). Terry and Hogg (2001) argue that similarities between individuals are perpetually accentuated in order to construct stereotypes (Terry & Hogg, 2001). In the present study stereo-typical nursing) based on technical, task driven activities associated with high acuity medicine were used to validate separateness between nursing and midwifery practice, even though these tasks were also completed by midwives within maternity units. A complex and contrary process of identification and accentuation is illustrated. The only clear midwifery practice identifier
without contradiction, was attending births. The activity of birthing women offers a “defensible position” (Abbott 1988, p.864) of midwifery specific practice.

Exaggeration of the defining characteristics helps to accentuate the descriptors that signify distinctiveness and group solidarity (Hogg and Terry 2000). Terry and Hogg (2001) argue that people will favour shared values to validate their behavioural responses. The notion of a categorization-accentuation process suggests that the tendencies to exaggerate differences is to be expected (Hogg, Terry & White, 1995). Therefore, it should not be surprising that midwives were emphasizing their role in ‘normal physiological birth’ as the only clearly defined and supported midwifery practice domain.

It can be argued that the professional categorisation, identity and boundary confusion demonstrated in the findings of this research are illustrated in connection with complications in pregnancy and birth or women’s pre-existing medical conditions. These are associated with medicine and then by further association, with nursing. The perceptions reflect some recognised midwifery professional philosophy and professional directives (ACM) (Evetts, 2013, 2003; Scott, 2008, 2010). Normal physiological pregnancy and birth (ACM, 2011) creates the conditions under which midwives establish their professional identity, and sets the boundary which accentuates deviations from normal as the defining features outside of midwifery scope of practice. Therefore, complicated pregnancy and birth as defined in the ACM ‘Consultation and Referral document’ (2013) outlines conditions that necessitate the ability to care but also referral to an obstetrician (ACM, 2013) and hence become a medical concern and may challenge ideals of midwifery practice.

As can be seen from the discussion an idealised category of a complete midwife emerges from a need to understand practice and registration renewal requirements. Considering the changed environment of national registration with separate registers, dual registrants used boundaries, and developed notions of self as a midwife, or a nurse, based on where they worked, their practice role and service type. What makes a complete midwife is multifaceted due to different expectations of midwives of themselves, other professionals, and women’s perspectives (Borelli, 2013).

Categorisation of midwifery practice is not a new phenomenon (Stevens & McCourt, 2002; Taylor, 2009; Hunter, 2004; Lane, 2002). Previous research has attempted to address
this issue. Billy Hunter (2004) identified that midwives in the UK who have traditionally practised in and out of hospitals were found to categorise their philosophical positioning as either “with institution” or “with woman” based on the confines of their practice location. Other authors, including Borelli (2013), Nicholls, Skirton, and Webb (2011), Kennedy & Shannon (2004) and Nichols and Webb (2006) reviewed the values placed on the characteristics of the midwife, rather than the extent of their practice activities. The findings of this study contribute to these characteristics from the Australian midwife’s perspectives and propose that the crux of being a “good midwife” (Borelli, 2013; Nicholls et al 2011), “real” (Stevens & McCourt, 2002), or complete midwife (Gray et al 2016) relate to being able to verify/validation competence for registration renewal. Continuity of care across the childbirth continuum is recognised in the literature as best practice - evidence based care (Sandall, Soltani, Gates, Shennan, Devane, 2013; Hatem, Sandall, Devane, Soltani, Gates, 2008). In this study the service type contributed to categorisation. In a number of maternity service models in Australia midwives will not regularly attend births. The findings reflect how this might impact on midwives, reflected in concerns about meeting midwifery RoP based on not attending births because of the type of service worked in and thus not ‘complete’ in their midwifery practice. Completeness is thus idealised or accentuated as a category of professional practice.

**Blurred boundaries and professional identity**

The finding of ‘completeness’ in midwifery identity as an ideal reveal not only what individuals may be thinking and doing about meeting registration renewal requirements, but also reflect the dynamic production and re-production of midwifery practice in Australia and the midwifery profession (Suddaby & Viale, 2011). Hogg and Terry (2000) argue that individuals are likely to exaggerate the desirable attributes to emphasize the salient characteristics, qualities, attributes of the group to lessen the uncertainty and increase cohesion during times of uncertainty, such as the changed registration renewal context. The findings of the current study have illustrated this process in professional construction. However, the findings also reveal blurred boundaries and categories. The greater fluidity this suggests leads to discussion of the role for a less specialist midwife identity to continue to develop and provide support to birthing women in Australia. The continuum illustrating this (figure 2) shows shared practices, roles and services although the findings as reported in
Paper 3 identified that this blurring was not without tension, confusion and inconsistency. Publication 2 (Gray et al, 2015) reports how at an individual level tensions and contradiction resulted over the blurring of boundaries in the care of women and infants whose care fell outside the limits of normal physiology, as women and infants could then be considered ‘patients’. One example given was the care of a woman who had undergone a caesarean section. The philosophical approach of midwifery care views the woman as well and healthy, therefore care for a woman who is now defined as a patient requiring medical or nursing care after a caesarean section puts professional identity, potentially at least, at loggerheads with this ideal.

Commonality between nursing and midwifery roles has been recognised by the national registration board of Australia “certain elements of practice are common to nursing and midwifery” (NMBA, 2013(a) p.2; NMBA, 2015(a)). This is because nurses and midwives share basic educational preparation focusing on principles of health promotion and primary health care and the development of affective skills such as communication, caring, advocacy, and research, which could all serve to demonstrate commonality for registration renewal purposes. One example of a commonly shared scope of practice is the public health role (Australian Nursing and Midwifery Federation (ANF) 2009). Two documents; Primary health care in Australia: A nursing and midwifery consensus view (ANF, 2009), and Primary health care reform in Australia (Commonwealth of Australia, 2009) both acknowledge the multidisciplinary role of public health, and the place of nurses and midwives in providing care that addresses prevention of disease and maintenance of health, not simply the treatment of illness. Even so, in Australian the public health role of the midwife has rarely been acknowledged (Biro, 2011; Bick, 2006). Public health agendas focus on working towards increasing the primary care role of nurses and midwives, which mostly requires working seamlessly across community and hospital. The findings of the current study illustrated some understanding of this focus but also tension and confusion with the service types and roles functioning as detractors from these principles and the interpretation of midwifery care requiring continuity and so service in antenatal and birth settings, largely within hospitals, creating a boundary for many.

Literature has identified the public health identity within midwifery. Lane characterised the hybrid midwife (Lane, 2002) and Taylor (2009) the public health midwife.
As discussed in Paper 3 (Gray et al, 2016) these two researchers both discuss categories of midwife as possessing practice characteristics that serve the public maternity service needs that are mainstream in the Australian context. Essentially, these researchers highlighted the different way in which midwives with dual registrations practised in Australia before the introduction of the separate midwifery register in 2010. They hinted at constructs of legitimacy within the profession, based on common ground in terms of practice and place. Their categories emulate practice that is fluid, and able to adapt and change according to the service environment, such as extending midwifery-led services within the public sector (Lane, 2002; Taylor, 2009).

The findings of the current study emphasised a focal point for the concern over place, and role for practice. It can be argued that the tendency to perceive the need for rotation to all areas of the maternity services was an attempt to meet the requirements of service employers, and professional bodies rather than meeting the definition of practice used in the RoP standard. The findings from this study have broader implications that potentially may impact on professional registration (practice standard), the professionalisation project, and workforce planning.

**Implications**

The practice definition set out by the NMBA is adept at describing nursing and midwifery practice in any role, caring for any patient and does not refer to clinical setting or direct midwifery care with woman or infants, as illustrated here:

“Practice is described as any practice in any capacity such as; clinical practice, or non-clinical, such as research, academia, or management, and covers practitioners working in any environment in and out of hospital” (NMBA, 2010 (b)).

Despite the inclusive nature of the definition enabling accommodation of nursing and midwifery practice the findings suggested that the changed registration renewal environment was confusing for dual practitioners in terms of how to interpret and meet the standards for RoP in a way that the midwives perceived equipped them to meet the separate national midwifery register and the maternity service requirements. This in turn led to increasing articulation of an ideal identity of midwifery.
The findings in this study expose the trend toward an increasingly specific and defined sphere of expertise or specialisation. They reflect a process of professionalisation in which categories define and locate professional legitimacy, or alternatively exclude certain practice (ACM, 2013). Promotion of ideological beliefs is synonymous with promotion of professional identity (Apker & Eggly, 2004). Claiming normalcy defines how midwifery is unique and different from nursing and separate to medicine.

Midwifery claims normalcy of physiological pregnancy and birth as the professional identity of the midwifery profession and a philosophy of being “with women” and providing care within a midwifery partnership relationship (Pairman, 2010). The midwifery profession refers to their scope of practice as normal, providing low risk care, which focuses on the normal physiology of childbearing and wellness, caring for healthy women and babies. The provision of midwifery care in a continuity of carer model providing care from a known midwife during normal pregnancy and birth is viewed as holistic, woman centred (Sandall et al, 2013) and an ideal. Within the domain of the independent, private practice midwife these characteristics are coveted as ‘specialist’ care. This professional strategy acts to create boundaries of practice (Montgomery & Oliver, 2007) and to set up agreed similarities (Terry & Hogg, 2001) in a bid to promote cohesion of members, and to avoid conforming to the increasing technological interventions in maternity care (Wagner, 1994, MacColl, 2009; Odent, 2011).

The institutionalisation of midwifery practice, and the professionalisation of midwifery nationally and internationally are key influences in the perspectives of midwives, and their decision-making around registration renewal options. In Chapter 1 historical events that shaped the profession were presented that told how the role and status of midwifery in Australia saw midwifery registration and practice standards enveloped by nursing into hospital institutions and medical models of care in 1928. Amalgamation of midwifery as a nursing specialty or subsidiary led to endorsed registration, and the institutionalisation of maternity services which is reported as responsible for the demise of traditional midwifery as an autonomous profession (Dahlen, 2006; Fahy, 2007; Davies, 2003; Summers, 1998; Boggossian, 1998).

Although change within Australian maternity systems has been slow, the desire to rotate across the continuum of the maternity services within an employee model was
expressed in this research. Dual registration has provided a flexible, mobile and economically convenient workforce, but it has not enabled the midwifery profession to practise autonomously within an organisation. As a consequence, the midwifery profession has received criticism from maternity service reviews that have been critical about the lack of midwives’ uptake of their full potential (Australian Health Workforce Advisory Committee (AHWAC) 2002, Hirst 2005; Maternity Services Inter-Jurisdictional Committee, 2008; Commonwealth of Australia, 2009). The AHWAC (2002) and the Maternity Services Inter-Jurisdictional Committee (2008) both called for an extension of the traditional midwifery role. The introduction of the separate register and the endorsement for the ‘eligible midwife’ on the midwifery register in 2010 addressed this request. However, the introduction of national registration was an event that initiated reflective contemplation about what it means to be a midwife.

Reflection in regards to the changed registration renewal standards led to tensions around contractual agreements and dual registration status. Employment obligations and contracts reflect a source of reflection and tension in these findings with some participants confronted with the idea of being sometimes as a nurse and sometimes as a midwife. Previous literature has identified this issue in staffing and workforce management (Shallow, 2001; Yates, 2010). Dual registered practitioners are desired in some contexts. Yates (2010) argues that while this is an institutional approach to managing workforce costs, midwives in her study would have preferred to work as midwives (Yates, 2010, Yates, Kelly, Lindsay, and Usher, 2013; Yates, Kelly & Usher, 2011), but were limited by their location to working mainly as nurses. Nevertheless, Yates and Kelly, (2013) concluded that these midwives were willing to sacrifice their preference of midwifery practice, for the ability to work where they lived. The findings of this study in Paper 2 (Gray et al, 2015) show that where midwives did not rotate to nursing departments the rationale for maintaining both registrations were questioned as a consequence of the changed registration environment. In the new context of national registration where options now exist for single registration, health service employers need to consider the possible impact of an increase in single registrants on service provision.

It may be advantageous for employers to consider potential workforce planning issues in relation to dual registrants. If dual registration continues to be a contractual requirement of employment then employers, union bodies and employees’/union members
need to work together to establish commitment agreements around supporting practitioners with the maintenance of registration standards, for two separate registers.

These issues are contentious and suggest that for the development of midwifery as profession, service and practice in Australia there needs to be rigorous and transparent dialogue. This research has contributed to the dialogue by identifying and highlighting the issues, and through the process of sharing the findings and issues arising in a range of national and international forums and publications over the past four years.

**Recommendations for further research**

What is interesting are the contentious issues raised around midwifery identity, the separation of nurse and midwife identity and implications for the professionalisation of midwifery in contemporary Australia. It is recommended that further research is conducted in this space around values and beliefs of midwifery its practice and service types.

Further research is needed of subgroups within the midwifery profession such as, private practice midwives and single registrant midwives. These specific groups should be targeted in a bid to gather deeper understanding of the issues raised in this study. Further research into the consequential practice of dual practitioners who altered their registration post 2010 to either single register is warranted. Research is needed to further explore contemporary professional categories, boundaries and the possibilities for dual roles and services. Further research is required into the trend toward the private, specialist midwife and practice in Australia. Further philosophical investigation could examine the range of professional, issues associated with separation and enforcing dual registration on employees who wish to move to single registration.

This research did not examine private practice midwifery and so further investigation is warranted regarding their registration and professional identity development and idealisation.

**Limitations of the study**

The nature of qualitative research means that certain limitations are inevitable. Purposive sampling attracts rich in-depth information about a phenomenon. Convenience strategies infer participation by stakeholders who are usually motivated individuals or people who have a vested interest in expressing their view. In this study information was garnered
from practitioners working in a number of states and so variation and reflection on different settings and practice contexts was gained. However, it was not possible to recruit across all states and territories which is a limitation when investigating a phenomenon with national significance.

The strength of this study lies in the fact that the contemporaneous and longitudinal collection of data captured a unique time which may not be replicated but which illuminated practitioner’s responses to significant changes in their professional environment. Issues have been identified with significance for midwifery and nursing, maternity services and workforce planning more broadly. The findings are not generalizable, however elements of the findings that impact on the meanings related to midwifery practice are used in the recommendations which are considered transferable.

**Summary and Conclusion**

This study examined a distinct point in time, when midwives used to a registration system in which midwifery was an endorsement on a nursing register, were faced with a changed environment in which nursing and midwifery registrations were separate independent registrations. This study investigated midwives’ responses to the changed registration environment and how they negotiated tensions between opportunities and challenges, the implications of their reflections and decisions regarding their workplace, midwifery and nursing practice, and registration renewal.

The implementation of national registration afforded practitioners the freedom to move around the states and territories of Australia to practise nursing and midwifery without the need for multiple registrations in each jurisdiction. The introduction of the separate midwifery register was welcomed by participants as recognition of midwifery as a distinct profession. The opportunity to reflect on, articulate and define the separateness of midwifery from nursing was identified. The findings of this study introduce new knowledge, and depth of understanding about the how dual registrants in nursing and midwifery view their simultaneous registrations, and illuminate how they define their competence for each registration.

Themes of rotation and restriction emerged as a construction of reflection on how the changed conditions could be met. The new RoP registration renewal standards created
tension as the participants in this study evaluated where they were at, where they were practicing and how they practiced, and where they saw themselves going and whether or not they met the recency of practice standard for each register. A philosophical continuum along which the relevance of practice place, type of patient, practice activities and service type all held significance when deciding whether they could demonstrate RoP for nursing or midwifery registration renewal, or both. There was evidence of confusion over the official requirements on the part of individuals and organisations. Contractual requirements, the introduction of the separate register, and the commencement of the option of an endorsement on the register as an eligible midwife were all potentially influential in determining how midwives perceived they would meet the RoP standard.

There was unanimous support for the introduction of the National Registration and Accreditation Scheme. Selecting, undertaking and meeting CPD requirements was not an issue of significance. The registration standard was clear, and ongoing learning valued. Internal and external motivators were revealed. CPD was motivated by relationships with women and peers, as participants strived to be a ‘better or complete midwife’ for women and as a team member.

This study found midwives’ perspectives about their work to be highly significant in determining their registration-renewal behaviour. Perception about practice lies at the heart of decision-making about registration type. Themes of rotation, restriction and extension encapsulate decision-making in the findings.

The recency of practice registration renewal standard was far more significant. The findings reveal that most midwives renewed their registration for both registers. The theme of rotation emerged as a result of participant’s’ discussions around meeting the RoP standard to demonstrate competence for each registration. There was a perceived needed to rotate to different areas of the maternity services, and occasionally rotate to nursing practice locations such as medical/surgical wards to complete specific tasks. Restricted access to attending births was revealed as a concern and impediment to meeting the RoP standard. This finding revealed important perceptions about requirements and ideals for midwifery practice and reflected in participants’ consideration about which register or registers to maintain and what implications that might have for the service and role they might need to undertake in the future to maintain recency.
The eligibility endorsement to the midwife register in 2010 was significant in the finding of Extension. It represented a professional idealisation and it may be argued represents a distinct area of specialisation in midwifery and services available to birthing women in Australia.

The theory of categorisation helped to identify directions in the professionalisation of midwifery. The role of the midwife was seen to have key categories, and boundaries, accentuated in order to distinguish it from nursing. These developed from reflections about the RoP requirement for each register and were problematic. Some elements of practice (such as birthing) were used to accentuate midwifery identity and validate professional membership while other practices (working in community) were seen as restrictive.

The significance of these findings are that before this study nothing was known of midwives’ perspectives of demonstrating competence of renewal for their midwifery registration. Drawing on these findings we can presume that before the change to separate registers how they determined RoP for registration renewal had not been an issue that received consideration. The changed registration conditions stimulated these midwives to reflect on their values and beliefs and articulate important aspects of their practice, role, career trajectories and understandings of both nursing and midwifery, as professions. The changed regulation and registration environment has increased registration options, has potential implications for workforce and service planning, and has raised discourse on the professionalisation of midwifery in Australia.
Post script

During the course of this research, the NMBA published a series of communication documents in response to the confusion experienced by practitioners (NMBA, 2012; 2012(a); 2012(c); NMBA, 2013(a); NMBA, 2015 (a)). Improved communication from the NMBA was called for in paper II regarding the RoP standard to clarify what is expected in relation to evidence of “practice”. The impact of the serial publications released during this study requires further evaluation to determine if there is sufficient information for practitioners when renewing their registrations. The research questions remain important for the NMBA because every time they make a change to the guidance they provide there is potential for confusion and further tensions.

One recommendation of this study was a call for the examination of the “practice” definition. On 23rd December, 2015 the NMBA website announced that, “AHPRA is seeking a suitably qualified and experienced Vendor to develop Midwife standards for practice, incorporating a review and analysis of the current NMBA National competency standards for the midwife (2006). This work is to ensure that the standards for practice reflect current midwifery practice and are up-to-date and relevant. The recommended standards for practice are expected to reflect current (not aspirational) evidence-based midwifery practice” (NMBA, 2015 (c), p.2).


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Appendices
The aims of NRAS include:
- protecting the public by ensuring that only suitably trained and qualified practitioners are registered;
- facilitating workforce mobility across Australia; and
- enabling the continuous development of a flexible, responsive and sustainable Australian health workforce.

The National Scheme has a number of objectives, including to:
- help keep the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitate workforce mobility for health practitioners
- facilitate provision of high quality education and training for practitioners
- facilitate the assessment of overseas qualified practitioners
- facilitate access to provided by health practitioners, and
- enable the continuous development of a flexible Australian health workforce. (p.7, AHPRA, 2011)

Appendix (B) Nursing and Midwifery Board of Australia (NMBA) regulation expectations for meeting the Continuing Professional Development Standard

In nursing and midwifery the NMBA (2010) specifies the following standard:

All nurses and midwives must meet the continuing professional development (CPD) standards. This standard sets out the minimum requirements for CPD which must be directly relevant to the nurse or midwife’s context of practice.

The requirements are set out as follows:

1. Nurses on the nurses’ register will participate in at least 20 hours of continuing nursing professional development per year.

2. Midwives on the midwives’ register will participate in at least 20 hours of continuing midwifery professional development per year.

3. Registered nurses and midwives who hold scheduled medicines endorsements or endorsements as nurse or midwife practitioners under the National Law must complete at least 10 hours per year in education related to their endorsement.

4. One hour of active learning will equal one hour of CPD. It is the nurse or midwife’s responsibility to calculate how many hours of active learning have taken place. If CPD activities are relevant to both nursing and midwifery professions, those activities may be counted in each portfolio of professional development.

5. The CPD must be relevant to the nurse or midwife’s context of practice.

6. Nurses and midwives must keep written documentation of CPD that demonstrates evidence of completion of a minimum of 20 hours of CPD per year.

7. Documentation of self-directed CPD must include dates, a brief description of the outcomes, and the number of hours spent in each activity. All evidence should be verified. It must demonstrate that the nurse or midwife has identified and prioritised their learning needs:

   a) based on an evaluation of their practice against the relevant competency or professional practice standards

   b) developed a learning plan based on identified learning needs

   c) participated in effective learning activities relevant to their learning needs

   d) reflected on the value of the learning activities or the effect that participation will have on their practice.
8. Participation in mandatory skills acquisition may be counted as CPD.

9. The Board’s role includes monitoring the competence of nurses and midwives; the Board will therefore conduct an annual audit of a number of nurses and midwives registered in Australia.

CPD standard – A four bullet point outline guides practitioners in their completion of CPD, and promotes reflection as an activity

The NMBA (2010) identifies that continuing professional development (CPD) helps health professionals to maintain, improve and broaden their knowledge, expertise and competence. The CPD requirements of each national board are detailed in the registration standards for each profession published on each board website. These requirements detail the number of credits/points/hours practitioners must spend each year on learning activities.

The functions of the Nursing and Midwifery Board of Australia include:

- registering nursing and midwifery practitioners and students
- developing standards, codes and guidelines for the nursing and midwifery profession
- handling notifications, complaints, investigations and disciplinary hearings
- assessing overseas trained practitioners who wish to practise in Australia
- approving accreditation standards and accredited courses of study.
Appendix (C) NMBA Requirements to meet the Recency of Practice (RoP) standard

Appendix (D) Approval letter from the Human Research Ethics Committee of the University of the Sunshine Coast

22 September 2011

Barbara Palmer
Manager, Office of Research
Tel: +61 7 5459 4574
Fax: +61 7 5459 4727
Email: humanethics@usc.edu.au

Mrs Michelle Gray
Dr Jennifer Rowe
Associate Professor Margaret Barnes
Faculty of Science, Health and Education

Dear Michelle, Jennifer and Margaret

Expeditied ethics approval for research project: How are midwives responding to the changed requirements for re-registration to practice in Australia? (S/11/360)

This letter is to confirm that on 22 September 2011, following review of the application for ethics approval of the research project, How are midwives responding to the changed requirements for re-registration to practice in Australia? (S/11/360), the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast granted expedited ethics approval for the project.

The Human Research Ethics Committee will review the Chairperson’s grant of approval and the conditions of approval at its next meeting and, should there be any variation of the conditions of approval, you will be informed as soon as practicable.

The period of ethics approval is from 22 September 2011 to 1 December 2013.

Could you please note that the ethics approval number for the project is HREC: (S/11/360). This number should be quoted in your Research Project Information Sheet and in any written communication when you are recruiting participants.

The standard conditions of ethics approval are listed overleaf.

If you have any queries in relation to this ethics approval or if you require further information please contact the Research Ethics Officer by email at humanethics@usc.edu.au or by telephone on +61 7 5459 4574.

I wish you well with the success of your project.

Yours sincerely,

Barbara Palmer
Manager, Office of Research

Web: www.usc.edu.au  Telephone: +61 7 5430 1224  Locked Bag 4 90 SIPPY DOWNS DRIVE
Facsimile: +61 7 5430 1111  MAROOCHYDORE DC QLD 4558  SIPPY DOWNS QLD 4556
   AUSTRALIA  AUSTRALIA
STANDARD CONDITIONS OF ETHICS APPROVAL

The standard conditions of approval for all human research projects are the following:

1. Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

2. Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Chairperson of the Human Research Ethics Committee by no later than the next working day after recognition of an adverse occurrence/event.

3. Provide the Committee with a written Annual Report on the research project by 22 September 2012 and on completion of the project on 1 December 2013 using the proforma "Annual Report on Approved Research Project Involving Humans". This may be accessed on the University of the Sunshine Coast portal at: Research and Research Training>Research Ethics>Human Research Ethics>Forms>Annual Report Form.

4. Advise the Committee in writing as soon as practicable if the research project is discontinued.

5. Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research project, please email your request to the Research Ethics Officer at humanethics@usc.edu.au, detailing the nature of the change and your reasons for the request.

6. Submit a written request for an extension of ethics approval using the proforma 'Annual Report on Approval Research Project Involving Humans' (see section 9) or otherwise apply via email. The request for an extension does not alter the need to provide annual reports on the dates referred to in condition (3) above.

Please note that compliance with these conditions of approval is a requirement of the University's Human Research Ethics – Governing Policy and the National Statement on Ethical Conduct in Human Research.
New Re-Registration Requirements

What's your experience?

Registered Midwives from all roles are needed for a research study to investigate how midwives are responding to the changed requirements for re-registration to practice in Australia.

- How have you met the re-registration requirements?
- What challenges and opportunities have you navigated to maintain registration?
- What are the issues?
- What decisions have you made?

If you would like the opportunity to share your thoughts and experiences I would love to hear from you. Individual and group interviews will be held around Australia to explore midwives experiences of the new re-registration requirements.

I am a midwife performing this research to complete a Philosophy Doctorate. Please contact me; Michelle Gray via email mgray@usc.edu.au or mobile 0435 010 648 for more information.
Invitation to Participate

Project: How are midwives responding to the changed requirements for registration renewal to practise in Australia?

Midwifery volunteers are required to participate in interviews to explore practitioners’ perceptions of the changes that have occurred in midwifery registration renewal to practice standards. Participants will be asked to talk about the impact the changes have had on their own practice, educational needs, and the challenges and opportunities they have faced since the implementation of the national Nursing and Midwifery Board of Australia (NMBA) requirements to demonstrate competence to practise through continuing professional development (CPD) and recency of practice.

This research study will use interviews to investigate and record the impact of the changes to midwifery registration renewal. Individual midwives will be asked to participate in two interviews at two separate time points. A sample of the midwifery population will be recruited for group interviews to discuss the findings from the individual interviews. The interviews are anticipated to last approximately 60 minutes and will be arranged at a time and venue to suit the participants. Interviews will be recorded and the conversations will be transcribed. Participants will be asked to confirm the authenticity of the interview. Participation in the research will be anonymous. Narratives will be coded to allow matching between the first and second interview.

Involvement in the project as a participant is voluntary. To be eligible for inclusion in this study, participants must be a midwife. Consent to participate now does not mean that you are unable to withdraw later. If you withdraw from the study your data will be removed from the study. The findings from this research will provide information that will assist education, service providers and professional bodies to plan and provide appropriate training and support for midwives that meet the needs identified by the midwives themselves and not needs perceived by educators, managers and professional bodies.

The research has been approved by the University of the Sunshine Coast Human Research Ethics Committee. If you are willing to participate, please contact Michelle Gray at the contact details below. An interview will then be arranged via email/telephone at a time, date and location of your convenience. You will be asked to sign a consent form to confirm consent to voluntary participation.

I am very keen to include you in this research; if you are interested and would like further information please contact:

Michelle Gray
Phone: 07 5456 5031
Mobile: 0435 010 648
Email: mgray@usc.edu.au

USC Ethics Approval No. (S/11/360)
Invitations for group participants

Invitation to Participate in Focus Group

Project: How are midwives responding to the changed requirements for registration renewal to practise in Australia?

Midwifery volunteers are required to participate in focus group interviews to explore practitioners’ perceptions of the changes that have occurred in midwifery registration renewal to practice standards. Participants will be asked to talk about the impact the changes have had on their own practice, educational needs, and the challenges and opportunities they have faced since the implementation of the national Nursing and Midwifery Board of Australia (NMBA) requirements to demonstrate competence to practise through continuing professional development (CPD) and recency of practice.

This research study has used interviews to investigate and record the impact of the changes to midwifery registration renewal. Twenty individual midwives have already participated in two interviews at two separate time points. A sample of the midwifery population is now needed for group interviews to discuss the findings from the individual interviews.

The interview is anticipated to last approximately 60 minutes and will be arranged at a time and venue to suit the participants. Interviews will be recorded and the conversations will be transcribed. Participants will be asked to confirm the authenticity of the interview. Participation in the research will be anonymous.

Involvement in the project as a participant is voluntary. To be eligible for inclusion in this study, participants must be a midwife. Consent to participate now does not mean that you are unable to withdraw later. If you withdraw from the study your data will be removed from the study. The findings from this research will provide information that will assist education, service providers and professional bodies to plan and provide appropriate training and support for midwives that meet the needs identified by the midwives themselves and not needs perceived by educators, managers and professional bodies.

The research has been approved by the University of the Sunshine Coast Human Research Ethics Committee. If you are willing to participate in a focus group at this conference please contact Kendall George: Mobile 0439994475

You will be asked to sign a consent form to confirm consent to voluntary participation.

I am very keen to include you in this research; if you are interested and would like further information please contact:

Michelle Gray
Phone: 07 5456 5031
Mobile: 0435 010 648
Email: mgray@usc.edu.au

USC Ethics Approval No. (S/11/360)
Appendix (G) Information sheets for participants

Research Information Sheet for Individual Interviews

Study: How are midwives responding to the changed requirements for registration renewal to practice in Australia?

Who is conducting this project?

This research is being conducted by Michelle Gray a member of staff from the University of the Sunshine Coast undertaking a Philosophy Doctorate, supervised by Dr Jennifer Rowe and Associate Professor Margaret Barnes. The team details are set out here.

Principal Researcher:
Michelle Gray, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54565031  Email: mgray@usc.edu.au

Principal Supervisor:
Dr Jennifer Rowe, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54565160  Email: jrowe1@usc.edu.au

Research Co-supervisor:
Assoc. Prof. Margaret Barnes, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54594686  Email: mbarnes@usc.edu.au

Why is this research being conducted?

Your participation in this research will provide valuable information that will help explore midwives’ responses to the recent changes in midwifery registration renewal. Your contribution will increase knowledge and understanding of the impact of the changed conditions on the individual practitioners. You may experience personal benefit through facilitated reflection. Larger potential benefits of the research to the future midwifery profession may include identifying issues which contribute to the support or inhibition of midwives’ practice, providing details of how midwives wish to be assisted in developing a plan for their continuing professional development needs, and ultimately improve the quality of our maternity services.

Who can participate in the research?

Participants will be midwives registered to practise and practising a range of roles, and services in different locations across Australia. Involvement in the project is voluntary and will involve being interviewed about your experience of the changed requirements for registration renewal to practice in Australia.

Your Consent
This participant information sheet contains information about the research project. Its purpose is to explain to you openly and as clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this information sheet carefully. Take your time and feel free to ask Michelle Gray questions about any information in this document.

Once you understand what the project is about and you agree to take part in it, you will be asked to sign the ‘Consent Form’. By signing the consent form, you indicate that you give your consent to participate in this research project. You will be given a copy of the participant information and consent form to keep as a record.

What will you be asked to do?

If you agree to take part in this research, you will be asked to do a number of things.

- Initially, you will be asked to read the information sheet and sign a consent form stating that you understand what the research is about and that you agree to participate in the research.
- The interview will be arranged at a time and venue to suit you.
- The interview will last between 60-90 minutes.
- As part of the interview you will then be invited to bring along to the interview an object that assists you to discuss how you have responded to the changed requirements for registration renewal (recency of practice, CPD and insurance).
- You will be asked to discuss your experience, thoughts, feelings, reactions, challenges, and opportunities experienced since the implementation of the changed requirements for registration.
- The interview will be recorded and transcribed and then you will have the opportunity to read the transcript and confirm the authenticity of the transcribed conversation.
- You will later be contacted and invited to participate in a follow up interview 6-12 months later.

Possible Benefits and Risks

You may benefit as a participant, by having the opportunity to discuss your responses to the changes requirements for registration renewal. We do not anticipate any risks associated with taking part.

All information collected during the interview will remain confidential, and anonymous. Information (tapes and transcripts) will be coded so that your identity will not be evident, and all data, transcripts and tapes will be securely stored at the University of the Sunshine Coast. Data collected will only be used for the purpose of this research. If you decide to discontinue your involvement in the project all data collected from you will not be used in the project.

The research team comprises of Michelle Gray a midwife and PhD student supported by academics with experience in the research method being used.

Your confidentiality and privacy

The information you share is confidential. Your contact details will be stored securely separate to the interview recordings and transcribed conversations so that you can be contacted for the second interview. A code will be used to connect interviews and any object. Any information in your interview transcript that may identify you will be deleted or changed to protect your privacy. The digital recording of your interview will be kept until it has been transcribed and authenticated by you. All recordings will then be deleted.
Any information obtained in connection with this project will be stored on a secure computer system. Written information will be stored in a locked filing cabinet, and retained for five years after the completion of the project. You may access the data you provided at any time during this period by contacting Michelle Gray. After the five-year period the data will be destroyed by shredding and burning. Identifying information will not be available to any individual outside the research team.

Results of project

This project will form part of a PhD thesis for Michelle Gray and be read by academic staff at the University of the Sunshine Coast and external examiner. The results of this project may be published in a peer review journal, and conference materials. In these documents there may be extracts from your transcribed interview; however, this information will be presented in such a way that you cannot be identified. Feedback about the project will be provided to you through a summary report.

Further information or any problems

The ethical aspects of this research project have been reviewed and approved by the Human Research Ethics Committee of University of the Sunshine Coast. If you wish to discuss the project with an independent person, or express concerns, contact the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast: c/- The Research Ethics Office, Teaching and Research Services, University of the Sunshine Coast, Maroochydore, DC 4558; Telephone (07) 54594574: Fax (07) 5430 1177; email: humanethics@usc.edu.au

Your assistance and contribution to this research is appreciated. If you have any further questions or concern about the research please contact the Principal Researcher Michelle Gray, the University of the Sunshine Coast – 07 5456 5031 or email: mgray@usc.edu.au
Research Project Information Sheet for Group Interview Participants

Study: How are midwives responding to the changed requirements for registration renewal to practise in Australia?

Who is conducting this project?

This research is being conducted by Michelle Gray a member of staff from the University of the Sunshine Coast undertaking a Philosophy Doctorate, supervised by Dr Jennifer Rowe and Dr Margaret Barnes. The team details are set out here.

Principal Researcher:
Michelle Gray, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54565031 Email mgray@usc.edu.au

Principal Supervisor
Dr Jennifer Rowe, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54565160 Email Jrowe1@usc.edu.au

Research Co-supervisor
Assoc. Prof. Margaret Barnes, Faculty of Science Health and Education, University of Sunshine Coast
Ph: 07 54594686 Email: Mbarnes@usc.edu.au

Why is this research being conducted?

Your participation in this research will provide valuable information that will help explore midwives’ responses to the recent changes in midwifery registration renewal and their impact on practice. The project seeks to understand change as it occurs, and contribute to the future of midwifery practice by providing details of how midwives wish to be assisted in developing a plan for their continuing professional development needs. Ultimately, this information will assist in improving the quality of our maternity services by identifying issues which contribute to the support or restriction of midwives’ practise.

Your contribution will increase knowledge and understanding of the impact of the changed requirements on midwifery practitioners. You may experience personal benefit through facilitated reflection. Larger potential benefits of the research to the future midwifery profession may include identifying issues which contribute to the support or restriction of midwives’ practise, providing details of how midwives wish to be assisted in developing a plan for their continuing professional development needs, and ultimately improve the quality of our maternity services.

Who can participate in the research?

You are able to take part in this project if you are a registered midwife. You will be practising in any range of roles, and service locations across Australia. Your participation is voluntary and will involve contributing to a group discussion about midwives’ responses to the changed conditions for registration renewal to practice in Australia.
Your Consent

Please read this information sheet carefully. Take your time and feel free to ask Michelle Gray questions about any information in this document.

Once you understand what the project is about and you agree to take part in it, you will be asked to sign the ‘Consent Form’. By signing the consent form, you indicate that you give your consent to participate in this research project. You will be given a copy of the participant information and consent form to keep as a record.

What will you be asked to do?

If you agree to take part in this research, you will be asked to do a number of things;

- You will be asked to participate in a group discussion with other midwives to comment on statements which have been generated from individual interviews with Australian midwives.
- The interview will take approximately 60 minutes and will be arranged at a time, date and venue to suit the group.
- Complete a confidential demographics questionnaire.
- You will be invited to discuss your experiences of meeting the new registration renewal requirements.
- The interview will be recorded and transcribed and then you will have the opportunity to read the transcript and make alterations if required. When you are happy you will be asked to confirm the authenticity of the transcribed discussion.

Possible Benefits and Risks

You may benefit as a participant, by having the opportunity to discuss your responses to the changed conditions for reregistration. We do not anticipate any risk associated with taking part in this research.

All information collected during the interview will remain confidential, and anonymous. Information (tapes and transcripts) will be coded so that your identity will not be evident, and all data, transcripts and tapes will be securely stored at the University of the Sunshine Coast. Data collected will only be used for the purpose of this research. If you decide to discontinue your involvement in the project, all data collected from you will not be used in the project.

The research team comprises of Michelle Gray a midwife and PhD student supported by academics with experience in the research method being used.

Your confidentiality and privacy

The information you share is confidential. Your contact details will be stored securely separate to the interview recordings and transcribed conversations so that you can be contacted to confirm authenticity of the transcribed discussion. Any information in your interview transcript that may identify you or specific work situation, will be deleted or changed to protect your privacy. The digital recording of the discussion will be kept until it has been transcribed and authenticated by you. All recordings will then be deleted.

Any information obtained in connection with this project will be stored on a secure computer system. Written information will be stored in a locked filing cabinet, and retained for five years after the
completion of the project. You may access the data you provided at any time during this period by contacting Michelle Gray. After the five-year period the data will be destroyed by shredding and burning. Identifying information will not be available to any individual outside the research team.

Results of project

This project will form part of a PhD thesis for Michelle Gray and be read by academic staff at the University of the Sunshine Coast and external examiners. The results of this project may be published in a peer review journal, and conference materials. In these documents there may be extracts from your transcribed interview; however, this information will be presented in such a way that you cannot be identified. Feedback about the project will be provided to you through a summary report.

Further information or any problems

The ethical aspects of this research project have been reviewed and approved by the Human Research Ethics Committee of University of the Sunshine Coast. If you wish to discuss the project with an independent person, or express concerns, please contact the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast: c/- The Research Ethics Officer, Office of Research, University of the Sunshine Coast, Maroochydore, DC 4558; Telephone (07) 54594574: Fax (07) 5430 1177; email: humanethics@usc.edu.au

Your assistance and contribution to this research is appreciated by the University of the Sunshine Coast and the researcher; Michelle Gray. If you have any further questions or concern about the research please contact the Principal Researcher Michelle Gray, the University of the Sunshine Coast – 07 5456 5031 or email: mgray@usc.edu.au

To participate in a focus group at this conference please contact Kendall George on M: 0439994475
Appendix (H) Consent forms for interviews

Consent to Participate in Individual Interviews

Research Project: How are midwives responding to the changed requirements for registration renewal to practise in Australia?

Ethics Approval Number: [Ethics Approval Number]

By signing below, I confirm that:

- I have read, understood and kept a copy of the Research Project Information Sheet:
- I give consent for data about my participation to be used in a confidential manner for the purposes of this research project, and in future research projects.
- I understand that if I have any additional questions I can contact Michelle Gray, the principal investigator.
- I understand that if I have any concerns about the ethical conduct of the project I can contact the supervisors of the project Dr Jennifer Rowe: telephone (07)5456 5160; email Jrowe1@usc.edu.au or Associate Professor Margaret Barnes telephone (07)5459 4686; email Mbarnes@usc.edu.au or the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast: telephone (07) 5459 4574; facsimile (07) 5430 1177; email humanethics@usc.edu.au.
- Any questions I had about this research project and my participation in it have been answered to my satisfaction.
- I agree that I will participate in the project.

Participant’s Name (please print) ………………………………………………………………

signature ……………………………………………………….. Date: ……………………

Researcher’s Name (please print) ………………………………………………………………

Signature ……………………………………………………….. Date: ……………………

Note: All parties signing the form must date their own signatures
Consent to Participate in Group Interviews

Project: How are midwives responding to the changed requirements for reregistration to practice in Australia?
USC Ethics Approval No. (S/11/360)

By signing below, I confirm that I have read and understood the information sheet and in particular that:

- I understand that in this research project the researcher is interested in professional practice and continuing professional development experiences.
- I understand that my involvement in this research project will involve participating in a group discussion (interview) with other midwives.
- I understand that the interview will be digitally recorded, that only the researcher will have access to recordings, and the recordings will be erased once they have been summarised and analysed.
- I understand that there may be no direct benefit to me from my participation in this research.
- I understand that all identifying information will be removed once all data collection has finished and that there will be no means of identifying me personally as a research participant in any publication, presentation or other means arising from the research.
- I understand that electronic hard copy information from the project will be kept in a secure system for a period of 5 years after the project is finished and then destroyed.
- I understand that my participation in this research is voluntary, and that I am free to withdraw at any time, without providing reasons or comment.
- If I do choose to withdraw from the research project at any time, any information received from me that was obtained during the research will not be used unless I state that it can be.
- I understand that if I have any additional questions I can contact Michelle Gray, the principal investigator.
- I understand that if I have any concerns about the ethical conduct of the project I can contact the supervisors of the project Dr Jennifer Rowe: telephone (07)5456 5160; email Rowe1@usc.edu.au or Associate Professor Margaret Barnes telephone (07)5459 4686; email Mbarnes@usc.edu.au or the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast: telephone (07) 5459 4574; facsimile (07) 5430 1177; email humanethics@usc.edu.au.
- Any questions I had about this research project and my participation in it have been answered to my satisfaction.
- I agree that I will participate in the project.

Participant’s Name (please print) ………………………………………………………………………………….
Signature …………………………………………………….. Date: ……………………

Researcher’s Name (please print) ……………………………………………………………………………………….
Signature …………………………………………………….. Date: ……………………

Note: All parties signing the form must date their own signatures.
**Appendix (I) Interview Procedure containing Aide Memoire for Individual Interview**

<table>
<thead>
<tr>
<th>Preparation for the Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact details for interviewee</strong></td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td><strong>Interview Location:</strong></td>
</tr>
<tr>
<td>Interview Date:</td>
</tr>
<tr>
<td>Travel details:</td>
</tr>
<tr>
<td>Map of location/directions:</td>
</tr>
</tbody>
</table>

| **Travel arrangements:** |

<table>
<thead>
<tr>
<th><strong>Equipment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital recorder and spare batteries</td>
</tr>
<tr>
<td>Note pad and pen</td>
</tr>
<tr>
<td>Private room, chairs</td>
</tr>
<tr>
<td>Do not disturb sign ‘interview in progress’ (if required)</td>
</tr>
<tr>
<td>Chocolate raisins</td>
</tr>
<tr>
<td>Water and glasses</td>
</tr>
</tbody>
</table>

| **Field Notes** |

| **Environmental factors:** |

| **Personal body language:** |

| **Object brought to interview:** |

| **Summary Notes:** |

| **Example Questions** (each interview will be different in structure and flow depending on the individual. The examples are prompts in the main discussion areas). |

| **Background of practice** |
Tell me your story of working in midwifery:
  • When did you qualify as a midwife?
  • Where you have worked?
  • Where are you currently working? Can you tell me something about your current role and work?

Exploratory Questions

Registration renewal as a midwife under the new APHRA requirements
  • What is your understanding of the new requirements that are part of registration renewal?

Exploring recency of practice
  • How have you met the requirement for recency of practice?

Exploring professional development
  • In what ways are you completed the continuing professional development requirement?
  • Has your approach to professional development activity changed in recent times (reasons)?

Facilitating/mitigating experiences
  • Has anything or anyone been particularly helpful?
  • Have you had any issues with meeting the requirements for registration renewal?

Future focus
  • Reflection – What influences will the changes have to your practice in the future? Meaningful / modifiable / valuable / challenging

Prompt if the ‘object’ has not been part of the interview -
  • What is the significance of your object?
  • What value does it hold for you?
  • Its meaning?

Notes
Appendix (J) Focus group procedure containing Aide Memoire

Focus Group Interviews Protocol

INTRODUCTION
Statement: Facilitate each participant opportunity to comment on their experience. This research project was undertaken to investigate midwives’ experiences of the changed registration renewal requirements that were introduced in 2010. Can you each share with me your experiences of meeting the changed conditions for registration renewal, for example the CPD and RoP standards.

Aim to provide participants with the opportunity to verbalise their views on this phenomenon. Then ask topic questions – ask participants to comment on categories created from previous participants’ interviews by asking them to comment on the posed statement and questions below.

FOCAL QUESTIONS
Possible directional comments;
- Something I have heard....
- Participants have identified....
- It appears that....
- Consensus suggests....

Category 1- Motivation
Statement: Individuals were asked to bring along an object to their first interview. Many brought gifts from women or mementoes/souvenirs/keepsakes of professional development activities [photos]. Participants in the study talked about the importance of relationships and their significance in motivating their choice of professional development.

Question: What are your thoughts around what motivates your choices of professional development?

Props:
- Take photos of gifts
- Laminated card with the NMBA 4 bullets points
- Paper for people to write what their own object would be and its importance to them personally.

Category 2 – Separate/Dichotomised Roles
Question: The majority of participants in this study were public health service employees and have stated that their employers have identified that their employment contract stipulates dual registration. Some of the participants have suggested that they feel they have no option to drop one registration. Consequently, this means they need to maintain both registrations. What is your experience?

Question: Participants have identified that when they complete activities for registration renewal that they are either nursing or midwifery focused – what is your take on that?
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