

AN ARGUMENT FOR A COLLABORATIVE FUNDAMENTAL CURRICULUM FOR  
NURSING AND MIDWIFERY EDUCATION

by

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## ABSTRACT

### An Argument for a Collaborative Fundamental Curriculum for Nursing and Midwifery.

This thesis examines the question "Is there a common curriculum base to the education programs of nursing and midwifery, sufficient to develop a collaborative fundamental curriculum?"

British Columbia is witnessing the newly-emerging profession of midwifery as a result of the Royal Commission on Health Care Costs released in 1991; this follows the position already taken in Ontario and Alberta. On the surface it appears that the problem of midwifery as an alternative obstetrical service has been resolved. In fact, however, it has brought into sharp focus the erroneous and obsolete views held by the nurses group and the midwives group about each other. This thesis examines the impact that historical, socio-economic and political factors have had on maintaining these perpetual misconceptions.

The author develops and proposes an argument for a collaborative fundamental curriculum for nursing and midwifery education in an attempt to eradicate the misconceptions and argues the case for a humanist philosophical approach to education using "basic encounter group" sharing as a means of promoting effective interprofessional understanding between the two professions.

The overlap between the two programs is identified and developed into a framework for a collaborative fundamental curriculum, based on the "clusters of influence" (Bevis, 1989), with its four identified curriculum influences. Although originally intended for nursing education, the concept of the clusters with a humanistic phenomenological emphasis, is pertinent to midwifery philosophy because it allows a broad scope for curriculum development that is firmly grounded in contemporary society; acknowledging the social history of women, the heritage of the profession, educational and research needs of the profession, while maintaining a vision for the future of health care and the people it will serve.

This is not to dismiss the technological/behavioristic models that have enjoyed a monopoly in health care thus far, but to suggest that a balance be found between the two philosophies, allowing technical training and education to coexist in the curriculum.

## DEDICATION

This thesis is dedicated to my dearest parents

Sydney Fredrick and Flora Wells

Vickers

Who gave me their love, friendship and constancy.

You are the bows from which your children  
as living arrows are sent forth.

The archer sees the mark upon the path of  
the infinite, and He bends you with His might  
that His arrows may go swift and far.

Let your bending in the archer's hand be for  
gladness;

For even as he loves the arrow that flies, so  
He loves also the bow that is stable.

Kahlil Gibran

Thank-you with love. Janet

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## Chapter One

### Background and Statement of the Problem

The purpose of this thesis is to examine the question: Is there a common curriculum base to the education programs of nursing and midwifery sufficient to develop a framework for collaborative fundamental curriculum?

Even at a casual glance the two professions appear to share a great deal of generic curriculum ground. This is the area that I intend to explore to identify the overlapping areas; the fundamental curriculum that can be developed into a collaborative partnership for the future nursing and midwifery programs.

The Oxford Dictionary (1991) defines the word fundamental as "the basis or foundation of a subject etc; essential". By fundamental, I specifically intend the word to refer to program philosophy and curriculum content that is generic to nursing and midwifery education programs.

#### **Midwifery - The Re-emerging Profession.**

In 1991, the Report of the British Columbia Royal Commission on Health Care Costs, chaired by Mr Justice Peter D. Seaton recommended that midwifery be legalized in British Columbia. Amongst the recommendations were:

Recommendation 32: - Pending the establishment of a College of Midwifery:

(a) Nurse Midwives be granted scope to practice under the Nurses' (Registered) Act,

(b) the Medical Practitioners Act be amended to make exception to midwives,

(c) Midwives be allowed to deliver babies in hospitals.

Recommendations 33, 34 and 35 dealt with the establishment of a college pursuant to amendment of The Health Professions' Act; that nurses be permitted to be members of both the Registered Nurses Association of British Columbia and a college of midwifery; and that costs associated with midwifery care not exceed those associated with physician care, respectively.

In March 1993, after extensive consultation with members and with other professional associations, the Registered Nurses Association of British Columbia (RNABC) released their position statement on midwifery and among the recommendations were:

- The RNABC believes that nurses who are qualified midwives should be able to choose to have their midwifery practice regulated by the RNABC under the provisions of the Nurses (Registered) Act,
- The RNABC also believes that qualified midwives who are not nurses should be allowed to practice and should be regulated by a College of Midwifery established under the Health Professions' Act,
- The RNABC supports the right of consumers to choose their providers, including alternative healers, the Association opposes midwifery by people who are not regulated because of significant risk such practice poses to the public. Therefore, the RNABC believes that traditional midwifery should be regulated (RNABC-March 1993).

As a result of the Seaton Report, the Health Professions Act was changed in 1993 and British Columbia is now witnessing the newly emerging profession of midwifery. This follows the position already taken in Ontario and Alberta.

On the surface it would appear that the issue of midwifery as an alternative obstetrical service has been resolved. However it has, in fact, brought into sharp focus erroneously held beliefs by the nurses' group and the midwives' group about each other. It has highlighted the dissension between these two groups, voiced misgivings regarding the anticipated education programs for the two professions, and has raised questions concerning the roles of nursing and midwifery and their respective clinical practice positions within the midwifery future of British Columbia.

The present day scientific, hospital-based, Canadian health care system and obstetrics evolved from health models originally imported into North America by the early settlers and immigrants (Arney,1982; Burtch,1994; Rooks,1986). The value placed on these scientific-based models combined with some shrewd political maneuvering by the medical profession, succeeded in negating and rendering the conventional female midwife role illegal (Arney,1982,p.19-50; Burtch,1994,p.10-20;160-7).

#### **Obstetrical Nursing - The Existing Profession**

At the end of the 19th century, legislation was enacted in British Columbia that put obstetrical care exclusively

into the practice of the British Columbia Medical Association and its members. As well as effectively outlawing the profession of midwifery, this legislation also excluded the professions of chiropractic, homeopathy and naturopathy. These professions and were only practiced over the subsequent decades clandestine and rarely.

All "non-medical" midwifery services were in a grey area outside the law, although not usually pursued by the law unless difficulties leading to birth fatalities occurred. As recently as 1988, the Registered Nurses Association of British Columbia released the document "Guidelines for the Practice of Registered Nurses in Licensed Health Care Agencies". This document clearly identifies obstetrical delivery as a non-transferable function;

Obstetrical delivery is a medical act, as defined by the B.C. Medical Practitioners' Act, and as such is the legal responsibility of the attending physician (RNABC, 1988 p.4).

Obstetrical nursing is a speciality of nursing, and the profession of nursing has historically viewed that with the progression of time, public opinion and legislative changes, this speciality area would ultimately become midwifery. To date, a high percentage of "obstetrical" nurses employed in British Columbian obstetrical units as are in fact:

1. foreign trained midwives, or
2. graduates of recognized nursing and advanced speciality nursing programs such as the Post-Diploma Nursing Specialist Program offered at British Columbia Institute of

Technology.

Both groups of nurses have many years of practical experience in obstetrics, but as practising members of the Registered Nurses Association of British Columbia, they are constrained from assuming any degree of autonomy in obstetrical care and are prohibited from legitimately conducting obstetrical delivery. At the same time, the reality is that case room nurse "midwives" are often faced with the dilemma of assuming responsibility for obstetrical delivery in the absence of the attending physician.

These nurses are also confronted by a second unenviable and frustrating situation. They must not only abide by provincial legislation but also by the guidelines of their professional association; both of which have prevented them from following their chosen career speciality as midwives.

#### **The Debate: Midwifery vs Nurse-Midwifery**

Kaufman and Renfrew Houston (1988) posed the question, "Is childbirth the exclusive territory of the midwife or is midwifery an outdated profession which is more appropriately regarded as a speciality of nursing?" (p.63)

This is not an question unique to British Columbia, nor even to Canada but is a topic that causes heated debate around the world. Proponents in support of nurse-midwifery cite a holistic approach to childbirth, an expansion of the primary health care role, and a return from the fragmented nursing role that presently exists in perinatal care. In fact

many believe that midwifery should be considered part of... "the ordinary calling of nursing"... (Wallis, 1988, p.54) and should be considered... "a primary health care role"... (Hinds, 1985, p.47).

Dr Halfdan Mahler, who was instrumental in the World Health Organization's promotion of primary health care, acknowledged that nurses had already begun shifting from the focus of health care, to the promotion of health. He foresaw role changes where nurses would become "resources to people rather than resources to physicians and moving from hospitals to work in the community" (RNABC, 1994, p.4).

Responding to the debate, Ernst (1992) poses many questions: "Is there evidence that being a nurse is a handicap to being a midwife?" (p.147) and "Do "direct-entry" midwives really hold special talents for practice (other than entrepreneurial talents) that nurse-midwives do not have? If they do, what are they?" (p.147).

Furthermore, Ernst (1992) discusses an important argument often raised by the non-nurse midwife, that of maintaining the "independent midwife" status and she further points out that all health care providers are interdependent. Hinds (1985) also agrees that "Maternity care is multi-faceted....no one professional group could hope adequately to meet the diverse needs of childbearing families" (p.47).

While many independent, non-nurse midwives define independence as "not taking orders from doctors" (Ernst, 1992, p.147), to most it means the ability to receive direct

payment for services. Ernst (1992) points out that direct payment is already a reality for the nurse-midwife in the United States.

It is difficult at present time to estimate how many foreign trained nurse-midwives there are practising as obstetrical nurses in Canada but according to Hinds (1985) there exists "a vast resource of well prepared nurse-midwives" (p.47). The nurse-midwife proponents point out that to utilize these well prepared nurse-midwives would be a cost-effective method of initiating a midwifery service in Canada. Burtch (1994) suggests that an expansion of the obstetrical nurse role is another possibility, that "nurses could help to meet the public demand for hospital-based midwifery" (p.203). In fact the recent legislation and subsequent midwifery curriculum development in Ontario has relied "heavily on input from nurse-midwives for its implementation" (Burtch,1994,p.204). This is also the case in Alberta (slightly behind Ontario in legalizing and implementing the new midwifery program) as well as in British Columbia.

Conversely, many of the proponents of non-nurse midwifery, contend that obstetrical and nurse-midwives are more inclined towards a "medicalization of birth and institutional based practice" (Kaufman & Renfrew Houston, 1988.p.79), and would, by their very relationship with the medical profession, lessen chances for an autonomous midwifery profession within the health care system (Kaufman &



Renfrew Houston, 1988, p.77 -79). They regard the nurse-midwife as an extension of the patriarchal medical system; that nursing will carry the patriarchy into female midwifery and that under these circumstances the midwife will never gain autonomy. Burtch (1994) states that:

In Canada, many midwives see the argument for nurse-midwifery as compromising the special relationship between client and midwife. Placing midwives under the supervision of physicians and within the compass of nursing would artificially restrict midwives' skills. It would also undermine continuity of care for expectant mothers, as midwifery would be assimilated within the conventional structures of the obstetrical team within hospitals (Burtch, 1994, p.212).

Burtch (1994) dismisses the argument of nurses co-opting into a dependent role by suggesting that "midwifery attendance could be brought within the ambit of provincial legislation such that nurses would be more self-directing in managing births" (p.204).

Kaufman and Renfrew Houston (1988) state that "nursing has moved from a dependent role of illness care towards an increasingly independent role incorporating health promotion" (p.77). They further discuss how nursing has altered its orientation over the centuries:

The current emphasis on health as well as sickness care, the development of academic programs with broadly based curricula, and the efforts to develop research based practice are but some of the indicators of change (Kaufman and Renfrew Houston, 1988, p.77).

According to the Standards for Nursing Practice in British Columbia, nurses are accountable and responsible for their practice (RNABC, 1992). The relationship between medicine and nursing is collegial, not legal and the courts

view nurses as independent, separate practitioners. Nurses are answerable for their own professional practice and cannot answer for another profession. Similarly, physicians cannot accept responsibility for nurses actions (RNABC,1994).

Kaufman and Renfrew Houston (1988) state that in the "struggles for increased recognition, autonomy and a collegial relationship with medicine, midwives are brought face to face with nurses and others who have the same goals" (p.78). This situation is influenced by the international historical evolvment of nursing and midwifery as professions, the complex organization of health services within the industrialized world and an increasingly democratization and education of society.

For centuries women have acted as unlicensed nurses, doctors, pharmacists, and counsellors. This changed with the establishment of the profession of obstetrics, the elimination of the midwife in Canada, and the education of women into nursing as "a calling" embracing the Victorian feminine virtues of duty and obedience. This has led to the outdated but still traditionally held notion of the subservient role of the nurse (Burtch, 1994; Ehrenreich,1990; Ehrenreich and English,1976; Kaufman & Renfrew Houston 1988) while health care professionals question the educational standards of persons functioning in British Columbia as "midwives".

### International Definition of a Midwife.

As already stated, "midwife" in Canada is generally assumed to be synonymous with home confinement, followed swiftly afterwards by the image of the "granny midwife" who is "generally assumed to be old, illiterate, ill-trained, and a hazard to health" (Hinds,1985, p.46). According to the literature, the title "midwife" has various interpretations around the world, depending not only on the country, but also on the economic and social development within that given country (Barclay,1986; Barclay, Andre & Glover,1989; Kaufman & Renfrew Houston,1988). According to Barclay (1986) "In many places in the world today the word "midwife" remains more a social description than a professional designation" (p.86).

The most widely accepted definition of a midwife came from the World Health Organization (WHO) in 1966 when they published the document Definition of a Midwife. This definition is still widely recognized in both the industrialized and third world countries (American College of Nurse Midwives,1992; Barclay,1985; Kaufman & Renfrew Houston,1988; Stewart & Beresford,1988; Thompson, 1990; United Kingdom Central Council-A Midwife's Code of Practice 1991; Wallis,1986). The WHO-Definition of a Midwife was also adopted by the International Confederation of Midwives and the International Federation of Gynecologists and Obstetricians in 1972 and 1973.

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has

successfully completed the prescribed course of studies in midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in other services.

(World Health Organization, 1966)

This is a clear definition of the midwife, midwifery education and clinical scope from the World Health Organization and should clarify the world position on this category of health provider. However, in reality the implementation of this definition differs considerably among different countries (Kaufman & Renfrew Houston, 1988).

Hall and Mejia, developed a set of "Classifications and Functions of Midwifery Personnel" which was published in a 1978 publication by the World Health Organization (see Appendix 1) and this has changed very little over the years. Although standards for the professional levels of midwifery education have increased since that time, the classifications remain relevant today. The professional levels are recognized and legalized throughout the western world, whilst the intermediate and non-professional levels are found mainly in third world countries.

## Definition of Terms

For the remainder of this paper, midwives will be referred to as:

- (a) Nurse-Midwife: A nurse-midwife is a registered nurse who has completed a recognized educational program in midwifery. A nurse-midwife's education and experience enable her to provide care and advice to women throughout their reproductive cycle, including pregnancy, labor, delivery and following birth. The midwifery component of the nurse-midwife education is at diploma or post-baccalaureate level (RNABC,1988).
- (b) Direct Entry Midwife: A direct-entry midwife is an individual who has completed an educational program in midwifery; educational preparation in nursing or another health discipline is not a pre-requisite. Direct-entry education and experience enable the individual to give the necessary supervision, care and advice to women during pregnancy, labor and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and mother. Direct-entry midwife education is provided in a school of midwifery that grants a diploma or degree (RNABC,1988).
- (c) Lay Midwife: A Lay midwife is an individual with no formal training from an accredited educational institution. Lay midwife education is provided primarily through experience and through an informal apprenticeship (RNABC,1988).

## Purpose

Having considered the background to the problem, I will specifically:

- explore the evolution of women healers, in particular the professions of nursing and midwifery, to examine the basis for the stereotypes and misconceptions held by members of the two professions about each other.
- critically examine the curricula of selected nursing and midwifery education programs, assisted by the "clusters of influence" described by Bevis (1989), to identify the program content that is common to both disciplines,
- develop a collaborative fundamental curriculum framework for nursing and midwifery education programs, based on the identified common program content. I am not suggesting that nursing and midwifery education become absorbed into a single program; both professions have very specialized bodies of knowledge to impart. What I am suggesting is that nursing and midwifery examine the similarities in their curriculum content, rather than dwell on their historical differences. I feel strongly that by educational collaboration on a fundamental curriculum the two professions could go a long way towards enhancing inter-professional understanding, helping to erase the "them and us" type of thinking.

**Method.**

The method of research used to obtain data for this thesis has included:

- an extensive literature search of nursing and midwifery history to examine the basis for the stereotyped misconceptions held by members of the two groups about each other.
- interviews with health care professionals and members of the general public, to examine stereotype perceptions of the roles of the nurse and the midwife,
- an extensive literature search to examine past and present education, standards for practice and legislation governing nurses and midwives,
- a comparative analysis of selected curricula from two nursing and two midwifery education programs.

**Limitations.**

Even at a cursory view there appears to be common ground sufficient to argue in support of a fundamental collaborative curriculum for all of the health care disciplines. As Northouse and Northouse (1992) observe "Health care professionals need to collaborate and cooperate with one another in order to help patients resolve complex health problems" (p.86). They go on to point out that although there has been a lack of inter-professional understanding, improvements have been made in recent years (Northouse and Northouse, 1992), for example, multi-disciplinary client care conferences are now standard in most health care facilities.

For the purposes of this thesis, however, research must be narrowed to examine the overlap areas between the curriculum of nursing and that of the newly emerging midwifery profession.

The legal status of midwifery has changed only recently in certain provinces and therefore I acknowledge the lack of an established Canadian Midwifery Programs to examine for curriculum comparison. The midwifery program of the Ontario Consortium Universities of Laurentian, McMaster and Ryerson Polytechnic Universities is in its infancy and has been operating for just over a year. It is therefore necessary to also look at an international midwifery curriculum. The selected curriculum is from Epsom and Kingston College of Nursing and Midwifery, England.

### Organization

1. Chapter One, in addition to describing the intent, limitations and organization, also contains a definition of terms used throughout the thesis.
2. Chapter Two provides an historical, socio-economic and political overview of the complexities surrounding the existing issues between nurses and midwives and their perception not only of each other but also of their own status within the health care system. There is conflict and fear on both sides and it is this author's opinion, quite apart from the positive aspects of sharing



resources, that inter-professional understanding can be enhanced by collaborative education.

In addition, Chapter Two provides an introduction to inter-professional conflict resolution (Northouse and Northouse, 1992).

3. Chapter Three examines the contemporary midwifery education and practice in selected industrial nations and presents a descriptive comparison of the four selected contemporary curricula, two nursing and two midwifery programs.
4. Chapter Four introduces behaviorist theories (Tyler, 1947), humanistic adult education principles (Knowles, 1970) (Bevis, 1989) and discusses the concept of "basic encounter group" learning, a component of humanistic adult education described by Rogers (1967), as a means of promoting interaction and growth. Utilizing these theories and assisted by the "clusters of influence" described by Bevis (1989), a collaborative fundamental curriculum framework is proposed.
5. Chapter Five discusses the conclusions and implications for future endeavors of a collaborative fundamental curriculum framework between nursing and midwifery education programs.

## Chapter Two

### Women Healers-From Witch to Academic.

Bevis (1989) makes the observation that "Progress requires memory. Memory enables us to analyze where we have been, where we are going, and to generate new approaches for bettering our efforts....to explore some of the issues that influence the next step-a step forward" (p.18).

The questions addressed in this chapter are:

- What is the basis to the out dated, anomalous, misconceptions held by nurse and midwives about each other? and how does one attempt to eradicate them?
- Do the future nursing and midwifery professions have to remain in isolation viewing each other with suspicion? or can professional strength be achieved by a fundamental collaborative educational unity?
- What does a fundamental collaborative education have to offer the professions of nursing and midwifery?

#### Women Healers

Charlatan, witch, handmaiden, ideal woman, thorough good women, physician's helper, unquestioning obedience, hag, crone, hopelessly dirty, ignorant and incompetent.

All these descriptive terms have been used to describe the woman healer(Achterberg,1990; Arney,1982; Ehrenreich & English,1978,1973; Miles,1993; Smith,1982; Ulrich,1992).

These terms have helped to reinforced the negative beliefs and ideas held by society of the woman healer. Most of these terms refer exclusively to women. For example, the word "witch" is not used as a masculine descriptive, although there were, and still are, male witches. Some of these words have even changed from their original meaning as a result of the persecution of the women healers. For example "hag" was once the pre-Christian word used for a follower of the Goddess and the ancient arts of Wica or witchcraft. The Oxford Dictionary now defines "hag" as "ugly old woman".

No doubt, some of these descriptives and the beliefs perpetrated by them, initially had validity whereas others, as this thesis explores, were pure propaganda. Unfortunately many of these outdated beliefs and misconceptions continue in today's modern western society. For instance, What is a nurse? I posed this question to members of the general public, physicians and finally to nurses themselves. All seem to agree that nursing is a "caring" profession but there the similarity of perceptions ends.

To the general public, the ideal of the nurse in the white starched uniform and cap, helper to the physician seems to epitomize the average person's concept. To the medical profession, "helper" "assistant" "organizer of my office/surgery" "person who gives care at the bedside". Rarely does one hear the response "work colleague".

And what of nurses themselves? How do they see themselves and the role of nursing? Segaric states that "More

and more nursing is being defined primarily on the basis of technical knowledge and skill nurses possess; care and compassion are less valued and fall secondary" (Segaric, 1993,p.16). She goes on to say that "The profession of nursing has reached a crossroads in its development as a result of the extremely difficult dichotomy in practice which tends to pit science and technology on one hand against nursing's traditional dedication to the ethic of human caring on the other" (Segaric,1993,p.18).

The oppression of women is the predominant factor to surface when one researches the literature regarding the evolvement of nursing and midwifery. Oppression, suppression, illiteracy and subservience mark the histories of both professions.

Lynaugh and Fagin state that "Oppressed groups are controlled by outside forces that have greater prestige, power and status and therefore can exploit the less powerful group" (In Bevis and Watson,1989,p.44). Women healers, once respected members of society, were repressed in medieval Europe, subjected to torture, death and outlawed to maintain the status quo of the powerful within society; namely the political and religious establishments. This led to the eventual ascent, during the eighteenth to twentieth centuries ) in western society, of a well-organized, politically astute male medical profession (Arney, 1982; Ehrenreich, 1990; Ehrenreich and English, 1976). Female healing and the arts of traditional healing became eclipsed and eventually controlled

by this group, allowing the rise of the modern scientific approach to healing and childbirth.

According to Watson (1989) "nursing is a clear paradigm case of women's oppression in society" (p.44) and Ehrenreich and English (1973) also relate in Witches Midwives and Nurses (1973,p.29) that the association between the devil, witches and midwives was so strong in the minds of the Catholic Church during the four centuries (15th-18th century) of witch hunting that midwives were singled out for special treatment. In 1484, witch hunters Kramer and Sprenger wrote "No one does more harm to the Catholic Faith than midwives" (Kramer and Sprenger,1971,p.66).

Historically it is difficult to separate the roles of the nurse and the midwife until the late nineteenth century as most health care was carried out within the home by women: family members and servants. "Women have always been healers" (Ehrenreich,1990,p.85), the nurturers within their families and within their communities. As Ehrenreich (1990) observes, skills were learned "from other women, often their mothers or grandmothers" (p.85). Women acted as midwives,as well as nursing family members and neighbors through illness and death. Caring for parturition, the sick, elderly and dying was recognized as "women's work", an expected extension of the feminine role in society. As Reverby (1987) notes "Embedded in the seemingly natural or ordained character of women, it became an important manifestation of women's

expression of love of others and thus integral to the female sense of self" (p.5).

The woman healer was an "empiricist" and "relied on her senses rather than on blind faith and doctrine, believing in trial and error, cause and effect" (Ehrenreich and English, 1973,p.30). She saw healing, not as a career but as a community responsibility and as a result "often gained respect and authority in their community" (Ehrenreich,1990, p.85).

The position of respect is maintained today. During the course of thesis research, I met, on numerous occasions, with two women traditional healers to learn more about the ancient healing techniques they use, and to discover the modern community role of the traditional healer. Both are well respected and are held in high esteem within their respective communities.

Marie Preisl combines traditional healing with a more orthodox approach as a registered nurse within a Vancouver hospital. Marie teaches and uses therapeutic touch, a contemporary interpretation of several ancient healing practices, when dealing with patients in a busy Vancouver orthopedic unit. Therapeutic touch was developed 21 years ago by Dr Dolores Kreiger, a professor at New York University and her colleague Dora Kunz. This technique is so effective that it is being utilized in such places as B.C. Cancer Agency and The Vancouver Hospital and is officially taught to nurses in

more than 80 colleges and universities in the United States and in 67 foreign countries (Brown,1993,p.17).

Bev Julian is a native traditional healer who learned the healing arts from her grandmother. A calm, gentle person of diminutive stature, she commands great authority within her community. She allowed me to accompany her to a healing meeting on a native reserve to watch her healing techniques. I discovered, as I talked with the Aboriginal people present, that Bev is held in high esteem and, by the way they spoke, also a good degree of awe by the First Nations' people. These two women healers are the modern day equivalent of the women healers, the "witch - healer", the wise woman.

#### **Professional Nurse? or Physician's Helper?**

"To Nurse" comes from the Latin verb "to nourish" and as Grove points out "is a commitment to stand by and be present through joy and pain, through sickness and health, through birth and old age, through death" (Grove,1991,p.44).

For centuries nursing had been carried out in the home as an accepted extension of the feminine, wife/mother role. The initial reforming steps, taken in the Western world towards establishing nursing education and trained hospital nursing personnel, came in the seventeenth century with the formation of the Catholic French Sisters of Charity. Their curriculum of training, with heavy emphasis on religious exercises, consisted of a two month probationary period followed by seven to eight months of clinical supervision and

instruction under the direction of Louise de Marillac (Bevis, 1989). As historian Abbe Casgrain records "the spirit of their vocation was the love of God....Hospital work exacts of every nun that she sacrifice herself for the service of the sick poor" (Grove,1991,p.45). Protestant nursing orders spread soon afterwards and followed similar nursing curriculum guidelines to those established by the Sisters of Charity.

The acknowledged founder of modern nursing was Florence Nightingale (1820-1910) who reformed hospital care and nursing in nineteenth century England. The already heavy influences of "duty" (women's' responsibility for family) and "obedience" (from nuns of religious orders) were now combined with the Victorian womanly virtues of "courage" "character" and "discipline" to produce the subservient "job" that was nursing. As Ehrenreich and English (1973) observe, "Nursing had not always existed as a paid occupation-it had to be invented" (p.52).

Initially the reformation of hospital nursing clearly had to involve a total change in the ideas and beliefs that English society held about nursing as an occupation. In the 18th and early 19th century hospital nursing was considered disreputable, classed alongside prostitution. Nursing was something that "well brought up" women simply did not do. By the mid 19th century the care of the sick, injured and dying was deplorable for rich and poor alike. In England, drunken women and prostitutes were often given the choice of serving



terms in prison or tending to the sick in a hospital. These "hospitals" were dirty, overcrowded places where the nurses often fought the sick for food and a place to sleep! The nurse Sairey Gamp, a character in the novel "Martin Chuzzlewit" typifies these caregivers and was one of the many social disgraces about which Charles Dickens attempted to educate his readers:

and give her a word or two of good advice now and then. Such," said old Martin, looking gravely at the astonished Mrs Gamp, "as hinting at the expediency of a little less liquor, and a little more humanity, and a little less regard for herself, and a little more regard for her patients, and perhaps a trifle of additional honesty.

#### Charles Dickens-Martin Chuzzlewit

As well as the social misfits who delivered this debatable care to the sick and dying, there were also the nursing sisters from religious orders who, as already stated, viewed their ministrations as a "calling" from God. For the "well-born woman" in Victorian England, to choose nursing as a job was a revolutionary move and was considered totally outrageous.

History records how Florence Nightingale and a group of 38 nurses in 1854, revolutionized nursing and the public's perception of nursing during and after the Crimean War. Their achievements in the Crimea were so outstanding that Florence Nightingale received recognition from Queen Victoria and became the first woman to receive the Order of Merit.

During her lifetime the wealthy, well-born, powerful Florence Nightingale gave respectability to nursing but in

return demanded control and unquestioning obedience to her perception of the nursing "cause". As Ehrenreich and English (1973) observe, "Nightingale was a little obsessive" (p.57) on the obedience point.

Let us be anxious to do well, not for selfish praise but to honor and advance *the cause*, the work we have taken up....Let it be our ambition to be thorough good women, good nurses, and never let us be ashamed of the name of "nurse".

Florence Nightingale (1820-1910)

In fact one could argue the case for indoctrination in the early reforms in nursing. One of the conditions of a doctrinal system according to Kazepides is "doctrines presuppose the existence of authorities and institutions which have the power to uphold them when they are challenged by the critics, the heretics or the faithless and to punish the enemies" (Kazepides,1987,p.235). In an attempt to give nursing its cherished respectability, its leaders demanded adherence from the rank and file to the Victorian womanly virtues of unquestioning obedience, dedication, selflessness and service to nursing and simultaneously submission to the hierarchy: all the qualities one would expect of a nun.

Nursing is said, most truly said, to be a high calling, an honorable calling. But what does the honor lie in? In working hard during your training to learn and do all things perfectly. The honor does not lie in putting on Nursing like your uniform, your dress....Honor lies in loving perfection, consistency, and in working hard for it: in being ready to work patiently: ready to say not "How clever I am!" but "I am not yet worthy; and I will live to deserve and work to deserve to be called a Trained Nurse.Florence Nightingale (cited in Achterberg, 1990,p.160).

Kazepides states that indoctrination "can be explicated only in terms of doctrinal beliefs which are religious or quasi-religious" (Kazepides,1987,p.229) and nursing was certainly reformed along the lines of a quasi-religious order. To quote Smith (1982):

She (Nightingale) distrusted Catholic and High-Church sisterhood vows because they enjoined obedience to a supernatural regime which deflected commands issued by rational mundane authority and provided an excuse for non-compliance. Nurses should nurse to meet God's purpose and to advance their personal quest for selflessness, but under human direction-as it turned out-Nightingale direction (p.22).

Nursing was called "Nightingalism" and nurses were called "Nightingales" in the early days of its reformation.

The School of Nursing at St Thomas' Hospital, London opened to probationers in 1860 and of course the class system of Victorian England invaded nursing education. There were two types of nursing students; lady probationers and ordinary probationers.

Training lasted for one year of probation, followed by three years of obligatory service. Probationers, according to the "Duties of Probationers under the Nightingale Fund" written by Florence Nightingale in 1867, were required to be "sober, honest, truthful, trustworthy, punctual, quiet and orderly, cleanly and neat, patient, cheerful, and kindly" (Nightingale,1867). As Bevis (1989) dryly observes "It can be presumed that at the end of their obligation, they were sainted rather than graduated" (p.20).

Florence Nightingale's influence and that of the nursing "cause" rapidly spread to the rest of the western world including Canada and the United States. The horrendous conditions exposed during the American Civil War had provided the impetus to examine the necessity for nursing training.

This training was ultimately based on "Nightingalism" with its heavy authoritative emphasis on obedience and service. This system maintained the status-quo of the nursing "cause" and in turn protected its leaders' power base. An early pioneer in the United States, Lavinia Dock is quoted in 1893 in an address given to colleagues:

Absolute and unquestioning obedience must be the foundation of the nurse's work, and to this end complete subordination of the individual to the work as a whole is as necessary for her as for the soldier. This can only be obtained by a systematic grading of rank, a clear, definite chain of responsibility, and one sole source of authority....concentrated in the head of the school as their representative and delegate (Chaska,1978, p.12).

In all fairness to Florence Nightingale, the demand for total obedience was probably necessary initially to bring together a respected, united nursing profession given the diverse backgrounds of its members; sisters from religious orders, bored ladies, prisoners, prostitutes and drunks. One questions whether the quasi-religious was the correct approach, and why this perception of the nurse has not become obsolete with the passing years?

Another area of obedience expected of the nurse, until fairly recent times, was towards the medical profession and is another area that emphasizes the quasi-religious;

subservience of the sisters of religious orders, and to the Victorian belief of the male as head of the household.

Chaska observes "Nurses for years have been taught that obedience is a prime virtue, with students and graduate nurses alike expected to follow unquestioningly the orders of doctors and their "superiors" in nursing" (Chaska,1978,p.14).

Lavinia Dock is also quoted as saying in 1893:

On one field only does the school properly come under the command of the medical profession, and that is in the direct care of the sick. Here indeed the command is absolute. Now for the first time in the history of medical science can its orders be carried out faithfully, fully and at all hours (Chaska,1978, p.12).

I do not detract from the importance of carrying out a medical order, however today's nurse is answerable to their own professional practice and would be held accountable by their professional association and the law, if necessary, for unquestioningly carrying out an incorrect or debatable medical order.

Medicine and nursing, along with other health care disciplines provide a team approach for health care. I agree that there is still room for improvement with inter-professional relationships within the health care team, however this outdated perception of nursing's subservience to medicine is one of the major misconceptions still clinging to the modern image of nursing.

Obedience and the quasi-religious also extended into other areas in nursing including titles of the hierarchy, uniform and personal life of the graduates and students.

Senior nurses are still addressed as "Sister" in many countries. Even the title "Matron" stems back to the Anglican marriage vows of Victorian England, "staid and chaste matron", female head of the domestic domain within the family home. In nursing, at the head of the nursing family within a hospital she was called "Matron" until fairly recently.

The nursing uniform is another area that was especially identified by members of the general public as epitomizing the image of nursing. Caps and uniforms certainly earned their place in Scutari and with good reason. The hospitals were rat and flea infested and the world had not woken up to asepsis, the science of bacteriology and the use of antibiotics. However the early uniforms bear a striking resemblance to the uniforms worn by women in service in Victorian England and again was another factor that helped to reinforce the nurse's subservient position.

Total and unquestioning obedience in nursing also extended to the personal life of the nurse and it remains in a modified form today. It is within the memory of many of today's working nurses, including this author, when dress, behavior and curfews were rigidly dictated and enforced by nursing administration. Ellis and Hartley (1992) state that "Codes of behavior were strict and well enforced" that students "who committed other acts of indiscretion were at risk of expulsion from the school" (p.55).

Initially the student never dared to question these dictates if she hoped to complete her education. Eventually

the student *never thought to question* the logic of these policies and accepted them as a normal part of the "nursing world" Indoctrination in early nursing reform? As Kazepides (1987) states "Successful indoctrination results in the acceptance of doctrinal beliefs and the commitment to them" (p.231). Nursing became a way of life to its participants and particularly during nursing training. The profession virtually controlled every aspect of the students' lives.

Kazepides states the prepositional modifiers such as "*into* and *with*, accompany the ordinary uses of the verb to *indoctrinate* (activity sense), suggest that the doctrinal beliefs must be specific. Thus one indoctrinates the young into the doctrines of a specific church" (Kazepides,1987, p.231). Nurses were educated "*into*" the world of nursing.

And what of the future of nursing? University and higher education were denied to women until the twentieth century and as a consequence medicine became male dominated, while nursing became female dominated. Over the past few years many women have entered medicine and conversely, an increasing number of men are entering nursing. Again this is a trend that is challenging the belief that caring is solely a feminine trait.

It's also interesting to note that the original thirty eight nurses in the Crimea dealt with 3,000 patients, most of whom were suffering from cholera and dysentery as well as severe wounds.

As Smith (1982) states after reviewing army records and correspondence of the time:

It also highlights the fact, which Miss Nightingale - followed by her biographers - managed to obscure, that the greater part of the nursing was done, as it always had been done, by male medical orderlies. She commandeered about 300 more of them than the army normally allowed" (p.43).

Work must also be done on an inter-professional level, to break the old stereotypes of "Nightingalism" as exemplified by the findings of a commission sponsored by the American Hospital Research and Education Trust and the American Hospital Supply Corporation were released in 1983.

As Ellis and Hartley (1992) state:

Many of the commission's findings were no surprise to people who are involved with nursing. Included was information that indicated that physicians and health care administrators often did not understand the role of nurses in patient care and that traditional and outdated images of nurses (including Victorian stereotypes and traditional male-female relationships) impeded acceptance of current roles. Some physicians and administrators perceived nurses as being over educated, and they did not support an increase in the nurses' authority to make decisions concerning health care. (p.44)

The nurse practitioner is now a recognized role within the health care system and their focus is illness prevention and health promotion. Ontario is presently dealing with court challenges from Ontario Medical Association and the Ontario College of Family Physicians, to changes in legislation that will allow nurse practitioners certain prescriptive rights, ordering certain laboratory tests and the fact that they will no longer be supervised by physicians.



Nurses in speciality areas have been carrying out physician functions for many years. For example, specially skilled nurses, trained in cardiac care are often the senior "in charge" health care professional running all facets of the emergency care at cardiac arrests, including ordering defibrillation, intravenous therapy and all necessary cardiac stimulant drugs. Similar examples can be cited in most areas of a hospital, not least of all, in the case-room and obstetrical areas.

Florence Nightingale certainly succeeded in raising the profile of nursing. "Nightingalism" became the world standard for nursing education and practice in the latter part of the nineteenth and early part of the twentieth century. In the process, nursing became subservient to medicine. Many contemporary misconceptions regarding nursing date back to this era and are very difficult to resolve while health professions remain in professional isolation.

However, as modern trends continue for higher nursing education standards, humanistic curricula that places value on "caring", the entry of more men into a traditionally female occupation, the higher profile of the nurse practitioner, inter-professional understanding and the education of society, maybe nursing can at last consign "Nightingalism" and its quasi-religious oppressiveness to history.

## Midwife? or Witch?

Midwifery is an ancient profession and is found "in some form in virtually all societies" (Rooks,1986,p.17). The English word "midwife" is derived from the Anglo-Saxon words "mid" meaning "together with" and "wif" meaning a woman. The word midwife literally meant "to be with" to assist the woman throughout the childbirth process.

By tradition, in all countries the birth attendant was female. In France she was known as sage-femme (wise woman), in German speaking countries as Hebomme (lifting, relieving or receiving nurse).

In pre-reformation times the status of midwife was viewed as an honorable position within society. Mention is made of midwives by the ancient Greek philosophers Socrates, Plato and Aristotle. Socrates is recorded as saying that midwifery was "a most respected profession" (Sweet,1989, p.597), while Hippocrates initiated education for midwives. There are also many references to midwives in the Bible. The Books of Genesis 35: 17-18; 38: 27-29 and Exodus 1: 16-21 all record the work of midwives (Sweet,1989,p.597).

In the second century A.D. the first textbook for midwives was written by Soranus of Ephesus, a Greek physician. For fourteen centuries this remained the only reference book for midwifery. Illiteracy and superstition mark the history of midwifery and have had a profound impact on the evolution of the profession. Few midwives were able to read with the resulting consequence that when another book on

midwifery "Ye Byrth of Mankynde" was published in the sixteenth century, it received limited use.

In sixteenth century England, midwives came under the scrutiny of the church in England. Birth was and still is perceived by some as an event surrounded by mystery, with spiritual and religious significance. The church was therefore anxious to control the "morality surrounding childbirth" (Arney,1982,p.22). Childbirth gave midwives access to the herbal folklore and "material used by witches". Since medieval times there had been an association in the minds of the church between midwives and witches. The church's concern was directed more towards the moral character of the midwife than to her competence.

Whilst England maintained church authority over midwifery, the training and licensure of midwives was controlled by the respective governments in Germany and France.

The once honorable social position of the midwife changed dramatically in Europe and England from the late 15th century through to the early 18th century. The age of the witch hunter had arrived. The unquestionable authority during these years, for both Catholic and Protestant witch hunters, was the *Malleus Maleficarum* (The Hammer of Witches) written in 1484 by two Franciscan priests, Heindrich Kramer and James Sprenger. This sadistic book and its authors received the blessing of Pope Innocent VIII and it is the very epitome of hate literature, preaching misogyny in every sentence.

Singled out for special consideration in the *Malleus Maleficarum* were midwives:

the greatest injuries to the Faith as regards the heresy of witches are done by midwives; and this is made clearer than daylight itself by the confessions of some who were afterwards burned (Kramer and Sprenger, 1971 p.140).

The subsequent torture and executions during that time have been estimated by various writers to be anywhere from 200,000 to numbering in the millions. Women made up 85% of those executed; old women, young women and female children. Many historians and feminist authors offer the hypothesis that the witch hunts during these centuries were no accident (Arney,1982; Ehrenreich & English,1973,1978; Miles,1993; Quaife,1987). The church offered little in the way of comfort to the poor. Pain and suffering, especially in childbirth, were considered the result of Eve's original sin thus to be endured. The traditional (usually women) healers were the only practitioners of medicine available to the poverty and disease stricken peasant classes, (male physicians dealt with the rich and powerful ruling classes) and thus they presented a threat to the male dominated status quo; the church, the ruling class and university trained physicians (Ehrenreich & English,1973).

These midwives and women healers, according to Miles (1988) had:  
an extensive repertoire of their own form of knowledge, incorporating elements of religion, chemistry, alchemy, botany, astrology, natural science and pharmacology. Their knowledge of herbs and poisons, for instance, would be likely to far exceed that of the most highly qualified male medical practitioner.(Miles,1988,p.136)

Miles also notes that the old images of the witch as a demented hag "have been undermined by more recent discoveries that they were very often self possessed, highly purposive, and above all young" (Miles,1988,p.136).

The "burning times" in the western world cemented the partnership of state, church and medical profession to maintain the patriarchal society. The physician was elevated to the position of "expert" to add the "scientific touch" to witch trials that took place during the 15th-18th centuries. Effectively this maintained the power base of the patriarchal governments and societies, the unchallenged authority of the church and the ascendent position of the profession of obstetrics.

The midwife based her practice on the conception that birth was a natural, normal process. The earliest male practitioners of obstetrics had appeared in the thirteenth century and were known as barber-surgeons. In Europe and England, barber-surgeons were viewed by midwives with derision and ridicule, called in French "sage-femmes en culottes" (midwives in breeches) and in English "man-midwives."

In England, the midwife and barber-surgeon were to continue to practice symbiotically for another couple of centuries and throughout this uneasy, relationship there were clearly defined lines of "normal" and "abnormal" births. The power lay ultimately in the hands of the midwife to decide when this line had been crossed.

In Europe the traditional practice of midwifery was beginning to change. In sixteenth century France, the scientific, obstetrical approach of the interventionist arrived. Public chartered hospitals, the Hotel-Dieu being the most famous, established midwifery instruction and provided the opportunity for midwives and physicians to observe many births. The concept of birth as a natural process changed. All physiological processes including birth were conceptualized as a component of the body as a whole organism. The role of the physician was to keep it working well and where possible, more efficiently.

The French "scientific" influence towards obstetrics arrived in Britain in the seventeenth century, along with midwifery text books, however once again illiteracy prevented most midwives from gaining theoretical knowledge. Universities and medical schools excluded women. In fact university education for women would be unheard of for at least another three hundred years. Experience was the only education available for midwives.

The scientific, rational, "body as machine" metaphor (Arney,1982,p.8) approach to birth effectively formed the conceptual basis for obstetrics, enabling men (physicians) to invade a previously banned area (Arney,1982,p.25). As a result midwifery changed drastically during the nineteenth and twentieth centuries to be overcome by the science of obstetrics. The technological developments combined with the blurring of the demarcation lines of "normal" and "abnormal"

births effectively removed the power base that had once been controlled by the midwife (Arney,1982,p.25).

Nineteenth century writers such as Charles Dickens left the public with the indelible character of the drunken, illiterate Sairey Gamp. The need for improvement was certainly highlighted by Dickens, but the impression left behind was that the services of the midwife were less desirable than those of the physician; that she provided a second class service.

The nineteenth and twentieth century saw the development of midwifery schools in Britain, Europe, North America and Australia. Nursing and midwifery became intertwined in many industrialized countries and as Rooks (1986) observes "in some countries nursing became a prerequisite for admission to midwifery schools" (p.17).

In Europe and Britain midwifery became professionalized with colleges of midwifery, education standards, and recognition in the form of registration and licensure. In North America, however, the picture was very different. Midwives were not well organized. They lacked professional schools, uniform standards and legal status (Rooks, 1986, p.17). Training was by apprenticeship and midwifery became "dominated in the United States by non-English speaking immigrants and lay midwives" to the poor and under privileged. "Midwifery became isolated from nursing, the hospital and academic medicine" (Rooks,1986,p.18).

Change towards nurse-midwifery began in 1925 when Mary Beckenridge imported British trained nurse midwives to form the Frontier Nursing Service in Kentucky. Rooks (1986) states that the resulting reduction in maternal and infant mortality "became a legend" (p.18).

In 1955 the American College of Nurse Midwives was formed. One of its objectives was to evaluate and approve nurse-midwife services and education programs. During the 1960s and 1970s there were also moves away from the "medical model of childbirth care" (Rooks,1986,p.19) by a well educated society and spurred on by the feminist movement.

In Canada, lay midwives were accepted as the normal standard by the early settlers. Burtch (1994) observes that while there are "biographical accounts of eminent physicians and chronicles of dramatic medical advances"(p.72) there is an "absence of historical documentation by and about Canadian midwives....in frontier and post frontier eras"(p.72) and therefore "historical writing has thus been limited"(p.73). Burtch (1994) goes on to say that within the then colony of British Columbia "historical accounts indicate that native midwives assisted settlers and cites Matthews (1945) who records cases from Moodyville, Hastings Sawmill, and Granville, where Indian women were the midwives.

The First Nations People have maintained traditional birthing methods and will probably continue to exert this right in future legislation. Traditional aboriginal healers and aboriginal birth attendants have been exempted from



legislation in Ontario (RNABC,1992, Workshop-Current Initiatives in Midwifery). The RNABC Position Statement-Midwifery "believes that traditional midwifery should be regulated (RNABC,1993).

With an increase in hospital births during the twentieth century and legislation at the turn of this century that effectively removed the right to perform deliveries by all but members of the medical profession, the speciality of obstetrical nursing evolved.

#### **Why Collaborate?**

It would appear that the centuries of power struggles surrounding health and healing professions remains very much alive in modern day Canada. It now includes nursing and midwifery as peripheral players. In 1993, while talking with the administrative personnel of the newly organized midwifery program in Ontario, I learned with considerable dismay that they were having to suppress their nursing qualifications because of existing tensions between the two groups.

I am a Registered Nurse (United Kingdom, 1966; Canada 1982) State Certified Midwife (1968) and Central Midwives Board Approved Training Midwife (United Kingdom, 1972) and have practiced midwifery in both hospital and domiciliary settings. I have accepted and appreciated the common ground between the two professions for many years and not once have I felt a personal conflict in duality of professions; in fact one compliments the other.

There is a great deal of common professional ground in providing fundamental holistic care, in this case, for the child-bearing family at an event of major importance in their lives. This requires a well educated, skilled practitioner who is able to respond appropriately.

Nurses would argue, that given the limitations placed upon them by the law, this already occurs. They already provide pre and post-natal education, caring physical and emotional support of the childbearing family during the ante/intra/postpartum periods, as well as applying the necessary knowledge and competence for delivery (in the absence of the attending physician).

Hinds (1985) makes the point that "Maternity care is multi-faceted, and as such no one professional group could hope adequately to meet the diverse needs of childbearing families" (p.47). Nurses who deal with obstetrical care would also argue the case that maternity care is provided in a multi-disciplinary Health Care Team approach. Nursing, as part of that team, provides expertise in the form of public health nurses, pre-natal nurse educators and clinicians, case-room nurses, maternity and nursery nurses. This is fragmented maternity care when one considers the true midwifery philosophy of continuity of care-giver, but again the legal constraints on nursing (see p.3-4) have dictated this position.

The Health Care Team is a multi-disciplinary team composed of all the health care professions. Its strength

lies in the respect for the "uniqueness and inter-dependency of the respective services of each discipline.

Interdisciplinary teamwork involves ongoing collaboration in order to serve the client well" (Guidelines for Specialized Nursing Skills and Delegated Functions, RNABC, 1992).

Although this is an RNABC directive, supported by the College of Physicians and Surgeons of B.C. it is relevant to all the participating health care professionals.

The Midwives Association of British Columbia, an association composed of many differently educated categories of midwives, maintains that professional autonomy is imperative for the newly emerging midwifery profession. Midwives I have spoken with have stated categorically that midwifery must remain separate from nursing; that nurses unquestioningly follow the orders of physicians and are "sickness orientated" functioning at a "medical model" level.

Kaufman and Renfrew Houston (1988) pose the question "Are they [nursing and midwifery] now sharing a far more similar perspective than ever before"(p.77). I agree with this statement and suggest that dialogue is now imperative between the membership of nursing and midwifery, to foster interprofessional understanding and collegiality. Midwifery is a new role that will be introduced into the British Columbia health care system in the near future, and irrespective of how these future midwives are educated, whether by a direct entry route, or by a dual entry route

i.e., direct entry midwives and nurse-midwives, collegiality can be enhanced by interprofessional role understanding.

Northouse and Northouse (1992) state that collegiality and collaboration have not always existed between health care professionals and identify three areas that have a disruptive impact on inter-professional relationships.

1. role stress.
2. a lack of interprofessional understanding.
3. autonomy struggles.

Role stress is a "fact of life" in modern health care settings, where one is constantly exposed to budget cuts, role overload, role conflict, scarce resources and cuts in programs. However as Northouse and Northouse (1992) point out, one of the most disruptive effects of role stress is a shift in priorities from interprofessional relationship building, to task orientated functions. There is an unwillingness by the professional to invest the necessary energy to build and maintain positive interprofessional relationships, tending, instead to focus on "getting the job done".

Lack of inter-professional understanding is the second area identified by Northouse and Northouse (1992), that has a disruptive effect on professional relationships within health care settings and they cite extensive research in this area. Lack of interprofessional understanding is subdivided into two main problem areas: lack of knowledge of one another's role, and territorial disputes. Both these areas have an

impact on nursing and the newly emerging profession of midwifery.

Lack of knowledge of professional roles starts in the professional education system. In 1971 Leininger stated that students spend from two - eight years in programs of professional education that take place in "virtual isolation from other health disciplines....with little exposure to the roles and skills of the other professionals" and that new graduates are "suddenly expected to collaborate with one another in a collegial manner, without any understanding about the other professionals' roles" (Northouse and Northouse,1992,p.90).

Theorists also found that the segregated educational experiences amongst health professionals leads to a restricted view of one another's roles and responsibilities (Kalisch and Kalisch,1977; Milne,1980) and this misunderstanding of roles, can in turn lead to professional tension and conflict.

The second problem created by the lack of inter-disciplinary understanding identified by Northouse and Northouse (1992) is an increase in territorial disputes. Due to the expansion of many health professional roles in recent years, there are now numerous areas of role overlap. Role overlap leads to confusion and conflict as to which professional actually has the expertise in a specific area Lister,1980; Mechanic and Aiken,1982; Weiss,1983, (as cited in Northouse and Northouse, 1992).

According to Northouse and Northouse (1992) "When health professionals' roles overlap considerably, it is not unusual for one professional to think that the other person is trying to take over his or her power and responsibilities" (p.91). This leads to unproductive competition.

The final area identified by Northouse and Northouse (1992) as a problem threatening interprofessional harmony, is autonomy, the right to be self governing and self directing. This is another area cited by midwives' associations as being imperative to the advancement and "coming of age" for the re-emerging midwifery profession. The degree of autonomy experienced by health professionals, according to Latinich and Schultheiss (1982), depends on three factors:

1. the permissible scope of practice for that group contained in state licensing laws;
2. the ability of that group to secure access to necessary health facilities, such as hospitals; and
3. the ability of that group to obtain reimbursement from private and governmental third party payers.

Latinich and Schultheiss' study (as cited in Northouse and Northouse,1992,p.93).

Physicians score well on the above criteria whereas other health professions compare less favorably. Admitting privileges to health care settings and reinbursements are less available to other health professionals. Silva, Clark and Raymond (1981) make the observation that when discrepancies are apparent in professional autonomy,"the

members of the dominant profession, tend to rate themselves higher in such areas as autonomy of judgement or evaluative skills than they would rate other health professionals" Silva, Clark and Raymond's study (as cited in Northouse and Northouse,1992,p.94).

Kalisch and Kalisch (1977) maintain that specific characteristics of other health professions, have led to their submissive position within the hierarchy of the health care professions. "Professions such as nursing with larger female membership have been deferrent (due to their socialization as women) to the predominately male medical profession. Kalisch and Kalisch's study (as cited in Northouse and Northouse,1992,p.94).

Northouse and Northouse (1992) observe that "Dominance of one professional group can lead to erroneous assumptions about control over other professions or to an exaggerated sphere of influence" (p.94), and Wesson (1958) states that this "dominance of one profession can interfere with the flow of communication between the higher and lower status professions" Wesson's study (as cited in Northouse and Northouse,1992,p.94). In the same study, Wesson also found that professionals tended to interact with members of their own group and as the distance grew between the professional groups, their interactions with each other decreased.

How then, does one foster interprofessional growth and understanding of professional roles between the professions of nursing and midwifery? Northouse and Northouse (1992)

state that as health professionals increase their understanding and familiarity with each others' roles, better use will be made of one another's expertise. They will feel less threatened by role overlap and it will lead to enhanced professional-professional relationships (p.92).

Collaborative fundamental education, discussed in the introduction of this chapter, has many positive aspects and have already proved to be cost-effective by avoiding duplication of courses and maximizing the use of facilities, equipment and instructors. In 1993 the Ontario midwifery education program was implemented in a collaborative partnership by the Ontario Universities Consortium. In British Columbia there is a move towards collaborative nursing programs for degree granting purposes.

The other additional factor in this instance, would be the exposure of nursing and midwifery educators and students to one other. Educative collaboration would facilitate educational and professional interaction and perpetrate a sharing of ideas, that will hopefully permeate the two professions and eventually break down long held stereotypes and misconceptions.



## Chapter Three

### A Descriptive Comparison of Selected Nursing and Midwifery Curricula

In most industrialized countries the title "midwife" is a legally protected title. This has not been the case in British Columbia due to the previously stated legislation and as a result there are many different categories of "midwife" in the province. The educational standard among these midwives ranges from those educated in recognized schools of midwifery with accredited standards, to those who have learned midwifery in an apprenticeship type of training, to still others who have received neither formal nor informal training/education in midwifery. Kaufmann and Renfrew Houston (1988) state that, "there is considerable diversity in midwifery education and clinical practice when international comparisons are made. These variations can affect the relationship between midwives and nurses and other health professionals" (p.64).

To examine the common curriculum content between nursing and midwifery education and practice in this chapter, it is necessary firstly to review the legal constraints for midwifery practice and standards for education from selected industrialized countries.

The Oxford Dictionary (1991) defines standard as "thing against which something may be compared for testing or

measurement; average quality; required level of quality or proficiency" and this is the definition that I intend the word to mean, whether I am discussing legal, practice or education standards.

The industrialized countries chosen for review of midwifery legal, education, and practice standards are the United Kingdom and the Member Countries of the European Economic Community, Australia and the United States of America.

Europe, and particularly the United Kingdom, have long provided vision and reform in nursing and midwifery programs. Australia also shares similarities with Canada. Historically, a colonial country and a British Commonwealth member country, and as such has maintained close legal and educational ties with the United Kingdom. Canada and the United States, geographically neighbors, also share a similar early nursing and midwifery history.

### **Contemporary Midwifery Education and Practice in Selected Industrialized Nations.**

#### **United Kingdom.**

In the mid-seventies the United Kingdom became one of the members of the European Economic Community. In 1979, the Nurses, Midwives and Health Visitors Act was passed and a United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visitors was established (Jane Winship, 1992 & 1994, personal communication). This effectively brought under

one authority the now defunct Central Midwives Board, the General Nursing Council for England and Wales and the Scottish licensing board. Scotland had up to this time, maintained its own licensing body. Sections 3 and 4 of this Act deals with Standing Committees of Council, one of these being a Midwifery Committee (Nurses, Midwives and Health Visitors Act, 1979, p.2-3). The mandate of the Midwifery Committee is the education, training, regulation and discipline of midwives (Nurses, Midwives and Health Visitors Act, 1979).

As a member of the European Economic Community, the United Kingdom was obliged to review its midwifery standards after a 1980 Council Directive 80/155/EEC(4) was enacted, for the mutual recognition of midwifery diplomas and certificates among the members (Official Journal of the European Community Legislation, 1980). Prior to this, nursing had been a pre-requisite for midwifery in the United Kingdom.

In 1989 the Nurses, Midwives and Health Visitors Act, required that the UKCC ensure that midwifery training meet the European Community obligations of the United Kingdom. As nursing was not a pre-requisite in a number of the European Community countries, a common ground had to be found. This led to the implementation of Pre and Post-Registration Midwifery Programs in the United Kingdom and for the first time allowed two different routes for midwifery education (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1992).

- (b) Post-Registration (Nurse-Midwifery)  
This is a program of not less than 18 months duration.
- (a) Pre-Registration Midwifery Program (Direct-Entry Midwifery). This is a program of not less than 3 years duration.

The Central Council also determined that the standard of both pre and post-registration midwifery programs should be that of higher education diploma and that the programs meet the Midwives Directive 80/155/EEC. Pre-Registration midwifery programs are required to resemble new programs in nursing education in relation to those aspects concerning links to higher education, the requirement for the program to be educationally led and the period of practical experience.

Miss Jane Winship, Midwifery Officer and Professional Advisor at the UKCC, stressed that both methods culminate in the achievement of the same learning outcomes (Jane Winship, 1994, personal communication). This means that the midwives practice rules and regulations, and the roles and responsibilities of midwives in the United Kingdom, do not differentiate between pre and post-registration midwives. All midwives are registered on Part 10 of the Council's Register and assume equal accountability for practice as midwives.

The total number of Midwifery Schools in the United Kingdom is 140. Of this total, 110 are Post-Registration schools and 30 are Pre-Registration midwifery schools. In the United Kingdom, the midwife is the senior person present at 75% of births and over 98% of these births occur in hospital

(Royal College of Midwives 1987a, In Kaufman & Renfrew Houston, 1988, p.65).

### The European Economic Community.

Midwives in the European Economic Community can receive education either as pre or post-registration midwives. Denmark, and the Netherlands have a direct-entry model, whereas in Sweden, midwives must first be prepared as nurses. All member countries are required to conform to the Council Directive 80/154/155/156/157/EEC. which apart from allowing free movement and employment within the EEC, also provides for the mutual recognition of the professional qualifications of Council Directive, covering midwifery personnel.

Directive 80/155/EEC states that midwifery education may be achieved by full time training in midwifery lasting at least 3 years:

- either subject to possession of a diploma, certificate or other evidence of formal qualifications giving right of admittance to university or higher education establishments or, failing this, attesting an equivalent level of knowledge and followed by professional practice of two years in an approved hospital or health establishment.
- full time training in midwifery lasting at least two years or 3600 hours subject to possession a diploma, certificate or other formal qualifications as a nurse responsible for direct care.
- full time training in midwifery lasting at least 18 months or 3000 hours subject to possession of a diploma, certificate or other evidence of formal qualifications as a nurse responsible for general care and followed by professional practice of 1 year.  
(Council Directive 80/154/155/156/157/EEC, Official Journal of the European Community-Legislation, 1980, p.1-16)

Spain is the latest member of the EEC. Midwifery

programs in this country are on hold at present, until they can be brought into line with the rest of the EEC Members.

#### Australia.

In Australia, nursing is a pre-requisite for midwifery training. According to Barclay (1985) direct-entry midwifery programs were discontinued quite recently. "The Federal Government's Directory of Courses, 1966, shows all States offering 2-year midwifery programs. Subsequent publications no longer show basic courses....Some time over this decade, the courses that were offered ceased" (Barclay,1985,p.93). Australian literature does support a dual entry system (Barclay,1985; Barclay,1986; Barclay, Andre & Glover,1989; Sledzik,1986).

Standards for midwifery practice vary in the different states of Australia, but they do have unanimity on the nursing pre-requisite. Midwifery education programs vary, depending on the state, in length of clinical and theoretical instruction. Queensland, for example provides a three year nursing program, with a further one year for midwifery, leading to a Bachelor of Science in Nursing (Nan Morganti, 1993, personal communication), while there has been the introduction of the Bachelor of Applied Science, (Advanced Nursing) Midwifery Major in Victoria for nurses holding a Diploma of Applied Science (Sledzik, 1986,p.46).

#### The United States.

Midwifery in the United States presents a complex and fragmented picture. On the one hand there is a well organized

profession of nurse-midwives, The American College of Nurse-Midwives, as well as,

a much more loosely organized and disparate group of midwives, variously referred to as lay midwives, empiric midwives, or practising midwives. None of these terms is entirely accurate when applied to the entire group (Kaufmann and Renfrew Houston, 1988,p.69).

It is impossible to refer to this group as either pre-registration or lay midwives because of the confusion existing regarding their education standards. There is a lack of organization amongst the group and many variants in their education standards (Ernst, 1992; Kaufmann & Renfrew Houston, 1988). As Kaufman and Renfrew Houston(1988) observe,

Some have extensive formal education in other countries but find they cannot qualify as CNM's (Certified Nurse Midwives). Some complete the formal 2 1/2 year education program at Seattle Midwifery School or complete other more abbreviated programs in midwifery. Many apprentice with a practicing midwife or a cooperative physician and learn the art or skills of midwifery over an extended period of time. Several have practised as nurses and have been drawn to alternative models of care (p.71).

The difference in education is also compounded by diversity in state legislation. In 1992, the American College of Nurse-Midwives surveyed U.S. state legislation and published the findings in the Journal of Nurse-Midwifery. Out of a total of 28 states, 26 required a midwife to also be a registered nurse. Non-nurse midwives are sharply divided from Certified Nurse Midwives (CNM) and practice outside the "institutional based health care system" (Kaufman and Renfrew Houston, 1988,p.71). They are closely associated with home births and their lack of standardized education programs and

national standards of practice receive strong criticism (Ernst, 1992; Kaufman & Renfrew Houston, 1988).

By comparison nurse-midwives are well organized with strong links between nursing and midwifery. The Certified Nurse Midwife (CNM) must first complete a nursing program and then an approved program accredited by the American College of Nurse-Midwives. Most of these programs are located in universities and have a nationally approved examination. Rooks and Haas in 1986 reported on a survey conducted by the American College of Nurse-Midwives that found almost two-thirds of the CNM respondents held a Masters' or higher degree. The accredited programs offered through the American College of Nurse-Midwives are;

#### Basic Certificate Program

This is a post secondary program that provides the essential components of the nurse midwifery curriculum as defined by the Core Competencies for Basic Nurse - Midwifery Practice.

#### Basic Graduate Program.

This is a post secondary program that provides the same curriculum components as the Basic Certificate Program and incorporates a program of professional studies leading to an academic degree at a master's level.

#### Pre Certificate Program.

This is a post secondary program for registered nurses, who are professional midwives. It provides selected components of the nurse - midwifery curriculum. Individuals eligible for this program must be registered nurses in one of the 50 states, District of Columbia or US Territories and must provide evidence of formal recognition in the country or state of preparation.

Upon successful completion of all of the above American College of Nurse-Midwives programs, the graduate is eligible to sit the national examination in order to become a



Certified Nurse-Midwife.(American College of Nurse-Midwives, 1992)  
Canada.

The Report of The British Columbia Royal Commission on Health Care Costs, chaired by Mr Justice Peter D. Seaton was released in 1991 and recommended that midwifery be legalized. The Royal Commission Report covered such issues as the establishment of a college of midwifery pursuant to the Health Professions' Act; that nurses be permitted to be members of both the Registered Nurses Association of British Columbia and a college of midwifery; and that the costs associated with midwifery care not exceed those associated with physician care.

Ontario passed legislation in November 1991, and the first formal midwifery education program was implemented at Michener Institute in October 1992. This was a nine month long program and the intent was to have midwives ready to practice after proclamation of the Act in Spring 1993. The Ontario pre-registration midwifery program was implemented in 1993 by an alliance of three educational institutions; McMaster University, Ryerson Polytechnical Institute and Laurentian University. Midwifery education in Ontario is required to be at baccalaureate level (Marilyn Booth,1993 personal communication).

Alberta also passed legislation legalizing midwifery in July 1992, for proclamation in early 1993. At present there is a program at the University of Alberta in the Master of

Nursing Program for Certificate in Nurse-Midwifery (Peggy Anne Field, 1992 & 1994 personal communication). British Columbia followed suit in 1993. There are presently no midwifery education programs in British Columbia although there is a post diploma Obstetrical Nursing Speciality at the British Columbia Institute of Technology. Other Provinces are considering midwifery legislation and are at varying stages in the process (RNABC, 1992, Workshop-Current Initiatives in Midwifery).

#### **Criteria for the Descriptive Comparison**

The purpose for the descriptive comparison of two nursing and two midwifery curricula is to provide direction for a collaborative fundamental curriculum framework, based on the common curriculum data identified from the selected education programs. When choosing curricula for analysis, I attempted to combine older, well established education programs, with, what I hope will be a fresh approach to curriculum development of newly functioning education programs.

Although the focus of the descriptive comparison was initially Canadian curriculum content, this proved to be difficult with midwifery curricula. Currently, the only midwifery education program functioning within Canada is the Ontario Universities Consortium, although the University of Alberta has a Masters in Nursing program, with an option to major in midwifery. It was therefore necessary to obtain one

of the selected midwifery curricula from the United Kingdom, a country well renowned for its leadership in nursing and midwifery.

The curricula selected from nursing are:

- University of Victoria. British Columbia School of Nursing - Collaborative Nursing Program
- Kwantlen University College. British Columbia Diploma Nursing Program.

The curricula selected from midwifery are:

- Ontario Universities Consortium (Laurentian, McMaster and Ryerson Polytechnic Universities) Baccalaureate Program in Midwifery.
- Epsom and Kingston College of Nursing and Midwifery in collaboration with North East Surrey College of Technology (NEScot). United Kingdom Registered Midwife - Diploma in Higher Education (Midwifery)

#### **University of Victoria - Collaborative Nursing Program**

In the fall of 1989, as a result of a government initiative to increase accessibility to baccalaureate education, the University of Victoria and four community colleges, Camosun, Cariboo, Malspina and Okanagan University College, formalized their commitment to collaborate on nursing education. This has since extended to include North Island College, Vancouver Community College-Langara and Selkirk Community College. Kwantlen University College, at present in the program planning stage, will be joining the collaborative consortium in 1996.

#### **Kwantlen University College-Diploma Nursing Program**

Kwantlen University College is presently undergoing major changes, both in its' academic direction and within the established nursing program. Early in 1995, the Provincial Government announced Kwantlen's new status, from that of community college to University College. The nursing program is also undergoing major curriculum design change, and in 1996, Kwantlen University College will become a participating member of the Collaborative Nursing Program.

As a result, the data for this thesis was obtained from the nursing curriculum that is currently in effect, a Full Time Diploma Nursing Program that has been operative since January 1989. Responding to community needs for flexibility, this program is also offered as a Part Time Diploma Nursing Program.

#### **The Ontario Universities Consortium-Midwifery Education Program**

The Ontario Universities Consortium Midwifery Education Program is a baccalaureate program in midwifery, that has been offered jointly since 1993 by Laurentian, McMaster and Ryerson Polytechnic Universities. The program is a shared venture among the three institutions, committed to the collective enterprise and joint academic and fiscal decision-making. Laurentian University is recognized for its distance education programs, and it is this institution that provides the base for a midwifery program in French.

**Epsom and Kingston College of Nursing and Midwifery in**

**collaboration with North East Surrey College of Technology  
(NESCOT) Registered Midwife-Diploma in Higher Education**

It is necessary to define the meaning of diploma level of health care education in England. Unlike in North America, the diploma in England is education taken at a higher academic level and is comparable to the baccalaureate level in North America.

In 1991, seeking to raise the level of post registration midwifery from Certificate to Diploma level, the Epsom College of Nursing and Midwifery and the Kingston College of Nursing and Midwifery formed a collaborative alliance with North East Surrey College of Technology. The course was designed to incorporate an in-depth multidisciplinary approach to theory to facilitate informed practice, in line with the English National Board for Nursing, Midwifery and Health Visiting (circular 1991/08/PAA April 1991). Previous post registration courses were evaluated and the results have formed the basis of the Diploma course.

The two midwifery schools, Epsom and Kingston, have a long and successful history in the provision of midwifery courses for Registered General Nurses.

**Clusters of Influence**

The criteria selected for the descriptive comparison, and the subsequent collaborative fundamental curriculum framework in Chapter Four, are based upon the "clusters of influence" described by Bevis(1989). This criteria was chosen

humanistic philosophical approach and in keeping with trends this seemed the most appropriate criteria to apply in the descriptive comparison.

The clusters of influence have four identified influences on curriculum: 1) needs assessment, 2) faculty role development, 3) general goals/ends in view, and 4) program content, and Bevis (1989) states that although there appears to be a sequential order to the clusters, this is in fact illusion and for process purposes there is "no one place to start" (p.111). These clusters of influence are so interwoven that "No one factor is powerful enough to be singularly persuasive in shaping curriculum. It is the interplay of a whole group of factors that, acting synergistically, influence the character and direction curriculum takes within a school" (Bevis, 1989, p.111).

Although originally intended for nursing education, the clusters of influence, with a humanistic phenomenological emphasis, are also relevant to midwifery philosophy and education. According to Barrows and Milburn (1990)

phenomenology literally means the account/study of appearances....In order to grasp the living meanings of the phenomena, researchers attempt to examine educational phenomena without the interposition of preformed assumptions, categories, or explanations. Their search is for the articulations of the structures of lived experience of human beings in educational situations and relations (p.241).

It is claimed that the clusters allow a broad scope for curriculum development that is firmly grounded within contemporary society; acknowledging the social history of

women, the heritage, educational and research trends/needs of the nursing profession, while maintaining a vision for the future of health care and the people it will serve.

### Content (Program) Cluster

For the purpose of the descriptive comparison of selected curricula, this chapter will focus on the Content Cluster only, to identify the curriculum content common to the selected nursing and midwifery programs.

Bevis (1989) states that when selecting curriculum content "socialization into nursing and the art and science of inquiry" are important considerations (p.142). Depending on the country, many nursing schools remain tied to the medical model. The curricula of these programs tends to be crammed with etiology, pathology, and the treatment of disease (p.142-143). It is this kind of content that Bevis (1989) describes as "watered-down doctoring instead of nursing" (p.143). This reinforces the misconception of nurses as failed doctors, already discussed in the preceding chapters.

As Bevis (1989) observes, nurses focus on the experience that people have with health issues. It is these experiences, that are not exclusively sickness, illness or disease related, which form the basis of the nurse/client relationship (p.143). While I agree with the concept of nursing focusing on the person's experience with health issues, I also feel that the nurse must also understand the

condition that has caused, or prompted the experience to occur in the first place. The nurse must understand the etiology in any given situation in order to be able to professionally support the person throughout the experience. The Content Cluster or Content of Nursing Cluster has four criteria:

1. Prerequisites,
2. Mission of the college or university,
3. Sources of content consisting of:
  - a) desired qualities of the graduates
  - b) structure of the knowledge base
  - c) culture of the field
  - d) needs of society
  - e) needs of nursing
  - f) health problems
  - g) interests/choices of the student
  - h) fields and disciplines contributing to nursing
4. Program of studies.

#### **Descriptive Comparison of Selected Nursing and Midwifery Curricula**

Criterion 1. Bevis (1989), states that although it has been traditional in collegiate nursing programs to concentrate on the sciences as prerequisites, the humanities and social sciences should occupy a strong place, given that nursing is in fact developing as a "human science" (p.141).

Although the sciences or current nursing registration dominate the academic prerequisites of the four selected programs, they also place major emphasis on an individual selection process to determine suitability of applicants, and therefore this will be included with Criterion 1.(p.65).



The University of Victoria, a participating member of the Collaborative Nursing Program operating three options A, B, and C, within one curriculum design, is directly involved in providing Options A and C. The participating member colleges and universities of the Collaborative Nursing Program have a collective agreement on admission prerequisites.

Option A of the Collaborative Nursing Programs involves completion of the program of studies in its entirety to obtain a baccalaureate degree in nursing and students choosing this option, enter the program at the community college level. The student must meet the general Undergraduate Admission requirements of the University of Victoria. These are general and non-specific in content, Grade 12 and university transfer courses. The student choosing option A, must show successful progression through years' one and two to be eligible for acceptance by the School of Nursing at the University of Victoria.

Option C of the Collaborative Nursing Program is designed to allow practising, registered nurses to bridge into the program, in order to graduate with a baccalaureate in nursing. The major prerequisite is active, practising registration.

In both options A and C, students are required to comply with the university requirements for first year university level English; English 115, or an equivalent, or to complete at least 1.5 units of the University's first year English.

Kwantlen University College requires a Science course (chemistry, physics or biology) in a combination of high school/university preparatory levels, as well as satisfactory scores in Mathematics and English language competency tests, completed before final acceptance into the program. Similarly the Ontario Universities Consortium require Ontario Academic Credit (OAC) courses in English and French (if applying to the French Program, based at Laurentian University), chemistry or biology and a social science, for direct high school applicants.

The consortium also has individualized institution policies regarding advanced placement in the program for qualified students, awarding credit for work undertaken in other post-secondary and/or experiential learning. They recognize that the individual backgrounds will vary widely and therefore individualized assessment is necessary.

The Ontario consortium state that they expect many of the applicants to the midwifery program will be mature students, and that personal maturity will be an important attribute amongst members of the midwifery profession, especially in the early years of integration into the health care system. In addition, up to five places are reserved for Native students, at full enrollment.

Epsom and Kingston College of Nursing and Midwifery/ (NESCOLT), requires that applicants be registered as nurses on Part 1 or Part 12 of the United Kingdom Central Council

(UKCC) Professional Register, and provide evidence of academic ability to study at Diploma level.

The Midwives Directive for the UKCC, March 1991, also requires that the student meet the educational requirements (Section A, Education Rules,30), for entry to a program of education leading to a qualification for admission to Part 10 (Registered Midwife) of the Professional Register (Midwives Rules, UKCC for Nursing, Midwifery and Health Visiting, March 1991, p.8-10). Although English Language and Science are specified as required subjects, the remaining three subjects are non specific and presumably are dependent either on the individual high school or student choice.

While all four schools place emphasis on the personal interview as a component of the selection process, three of the schools, Kwantlen, Ontario and England provided the most information. The English midwifery school, in particular, has a very detailed, concise selection procedure with clear, definitive criteria as to what constitutes the successful applicant, and they report that the interview process also meets the requirements of the English National Board (ENB) of the UKCC, the College and the National Health Service(NHS) Trusts of Epsom and Kingston.

In the three schools (Kwantlen, Ontario and England), the selection procedure is a three step process: academic eligibility: a review of the applicant's written personal submission: and finally the applicant is individually interviewed and assessed for the ability to further develop

personal and professional qualities. The areas explored are the applicant's personal attributes and qualities, maturity, attitude, manner, motivation and career goals. In addition, Kwantlen University College also assesses the applicant's ability to deal with stress, the support systems available and the financial burden that may be imposed on the applicant/family by a sustained period of education.

To summarize, the sciences, English or current nursing registration dominate the prerequisite courses. The Ontario Universities Consortium, specifies a social sciences as a component of their prerequisite and is the program that meets the criteria as described by Bevis (1989). However, the four curricula all place emphasis on an individual assessment and selection process and the four programs reflect the humanities and social sciences in their course co-requisites.

Criterion 2. The educational program content and goals must reflect the values of the parent institution; the mission and goals statements must be in harmony (Bevis, 1989, p.141).

The statements from the University of Victoria and Kwantlen University College were the most comprehensive, providing mission statements from their respective parent institutions, as well as program purpose and goals statements. They both address the concept of lifelong learning, in their respective parent institution mission/goals statement and program purpose/philosophy statements. Both program mission and goal statements remain

in harmony with their parent institutions, reaffirming a commitment to changing societal needs, flexibility and innovation in program design and collaboration with other disciplines, programs and institutions.

The University of Victoria combines the development of the university population and society in general, within its Mission Statement, promoting the advancement of national and international cultural, social, environmental and economic well-being. The Mission Statement of the University of Victoria states:

In serving the peoples of British Columbia and Canada, the University seeks, through its teaching and through its research and artistic and professional practice, to be a community of learning and knowledge judged to be excellent when measured by the highest international standards.

Combined to support the mission of the university, are eight goal, and five principle statements. Among some of the other principles stated are commitments to life-long learning and programs that increasingly connect university programs to the social, economic and environmental challenges by developing cooperative education, internship programs, interdisciplinary programs and research activities.

These statements are reflected in the Collaborative Nursing Program, which acknowledges collegial collaboration, future societal trends and the changing focus of nursing. Responsive to the parent mission and goal statements of the University of Victoria, they discuss educating nurses to work with individuals, families, groups or communities from a

health promotion perspective and with an ethic of caring.

The harmony between parent institution and program values is reflected yet again by the Diploma Nursing Program at Kwantlen University College. The parent Mission Statement states,

We create quality, lifelong learning opportunities for people to achieve personal, social and career success.

The Values and Principles statement provides the philosophical framework within which the mission is pursued. The statements reflect a humanistic philosophy, including a commitment to life-long learning opportunities, and cooperation with the community that will nurture the full personal, intellectual and cultural potential of its citizens.

The purpose of the Diploma Nursing Program reflects the values of Kwantlen University College, to provide a flexible, self directed, educational program....designed to assist students to develop the knowledge, skills and attitudes necessary to become safe, effective beginning practitioners. The nursing program philosophy statement provides further insight to the program, expanding the program purpose statement and reflecting the parent institution mission/goal statement. The statement was developed by the faculty and contains their beliefs about the five major influences that give direction to the program: 1.the individual; 2.health and health services; 3.nursing; 4.learners and learning and 5.nursing education.

Parent institution mission/goal statements were not provided by the remaining two programs, the Ontario Universities Consortium and the Epsom and Kingston College of Nursing and Midwifery in collaboration with NESCOLT, both of whom have recently undergone major, collaborative amalgamation to produce their current programs. However, both programs included, along with their curricula, extensive introductions and historical backgrounds, describing the administrative, inter-professional and regulatory representation that lead to their current, respective collaborative positions. In both countries, the curriculum development of the two programs was organized in an atmosphere of close liaison with their respective parent institutions. Although it is not possible to compare individual parent institution mission/goal statements, in both instances the extensive introductions and histories clearly demonstrate that there was a great deal of interaction between the respective parent institutions, as well as government and professional regulatory bodies, sufficient to expect that both collaborative programs are in harmony with their respective parent institutions.

Along with their curriculum, the Ontario Universities Consortium provided the joint proposal for a program leading to the degree, Bachelor of Health Sciences (B.H.Sc) in Midwifery, that was submitted to the Ontario government in September 1992 and was subsequently approved. The program was implemented in 1993, after many years of planning, utilizing

a broad network of advisory persons and groups from the three participating institutions, as well as governmental advisors, regulatory bodies and community groups. The introduction and historical background to the program states that the primary designers of the Midwifery Education Program represent the partner institutions of the Ontario Universities Consortium (Laurentian, McMaster and Ryerson) and that the program is collaborative, both in development and in design, drawing upon the strengths of each of the partner institutions.

The individual mission statements were also unavailable from the parent institutions of the collaborative midwifery program in England. However, as in the case of Ontario, Epsom and Kingston College of Nursing and Midwifery and NESOT provided an extensive historical background to a collaborative process that had taken place in an atmosphere of close interactive liaison by all the participating members. The English curriculum was developed to meet the challenges posed by new legislation, by greater scientific knowledge and technology and by growing awareness of the significance of social and psychological factors to the needs and responses of clients.

Both midwifery programs place emphasis on humanistic and androgological principles of adult education, placing value on life-long learning; the English refer to the concept of "education as a continual process". Both programs focus their educational purpose on flexibility, changing societal needs, professional and practice needs, and collaborative



interaction. The Ontario Universities Consortium incorporates a "statement of beliefs" with "guiding principles" and "features" of midwifery education, and specifically the Ontario program. There are 21 statements in all. The first seven statements relate to beliefs held about midwifery education; the participants and the educational environment. Learning is described as "accessible" "distance education" "flexible" and "culturally sensitive". The next seven fundamental principle statements form the philosophical framework of midwifery education and pertain to midwifery practice, while the final seven statements discuss the particular features of the collaborative program, such as part-time study and flexible scheduling.

Epsom and Kingston Schools of Nursing and Midwifery/ NESOCOT, in accord with Ontario, is a *midwifery led* program. They divide their program beliefs into three interlinking components, 1. Philosophy of Care, 2. Health Care, and 3. Educational Philosophy. The philosophy of care places value on holistic, family centered care and client informed decision making, changing trends and research, while the health care philosophy stresses "team approach", liaison and direct communication between health care professionals. The educational philosophy refers to the "training" as well as the "education" of midwives and stresses that midwives' need a critical awareness of the economic and political environment within which they will, and do, practise. They explain that in order to meet these demands, the course has

specifically been designed at the Diploma level, containing a wider knowledge base, and therefore expecting more of the students by way of critical reflection on their practice.

In summary, two of the four selected curricula, the University of Victoria and Kwantlen University College, provided parent/program mission/goals statements, and in both cases the program reflected the values of the parent institution addressing the concepts of life-long learning, collaboration and research.

Although there are no parent mission/goals statements from England and Ontario, both programs provided extensive histories to their present collaborative position, and in both cases the process occurred in close deliberation with their respective parent institutions. One can therefore suppose that the programs do indeed reflect their respective parent institution values and as in the case of University of Victoria and Kwantlen University College stressed life-long learning, collaboration and research.

### Criterion 3.a) Desired Qualities of the Graduate

Bevis (1989) states that the characteristics or qualities of the graduate are not to be confused with measurable behaviors. The educated professional nurse possesses the qualities and characteristics of true education, that are describable. Bevis cites some examples of qualities, consistent with the educative-caring paradigm as being: reflection, creativity, criticism, use of knowledge

regarding the structure of inquiry, analysis, uses of structure of theory and theorizing, colleague interaction ....ability to discern patterns, willingness to make intuitive leaps and take reasonable risks, use of research and use of others' knowledge, experience and expertise (p.145).

Three of the four curricula (Victoria, Kwantlen and England) specify the qualities of the graduates of their program, within their curriculum outline. The Ontario program incorporates the International Definition of a Midwife to define what constitutes a midwife. While this definition acknowledges the necessity and existence of the education/ prescribed course of studies and acquisition of the requisite midwifery qualification in the country in which the program is located, it does not address the concepts of continued personal professional development, the use of research nor the awareness of changing societal, political and cultural factors. However, these concepts are addressed, further along in the Ontario curriculum, in "plans for the future" (p. 21 and 22).

Ontario also combines the International Definition of the Midwife with the fundamental principles of midwifery that form the philosophical framework of midwifery education. The fundamental principles, termed in the curriculum as "guiding principles of midwifery education" contain seven statements. These statements deal with midwifery and professional

practise, rather than giving a broad picture of the expected graduate qualities.

The describable qualities of the graduate are dependent on the program philosophy. Kwantlen University College and Epsom and Kingston College of Nursing and Midwifery/NESCOT combine humanistic and behavioral philosophical beliefs within their curriculum design, and this in turn is reflected in the desired graduate qualities. For example, the current program at Kwantlen University College, based on a combination of self-directed humanistic adult education/behavioral training, uses the measurable behaviors of the program's Terminal Objectives to describe the desirable graduate qualities. The Terminal Objectives, with eight criteria, are also used in the programs' evaluative tool.

In summary the curricula from the University of Victoria and Epsom and Kingston/NESCOT, best demonstrate consistency with the desired graduate qualities, as described by Bevis. Epsom and Kingston/NESCOT, while conforming to the International Definition of a Midwife incorporated into the Midwife's Code of Practice (UKCC,1991,p.2), also provide an extensive program description of graduate qualities.

In the curriculum document for Epsom and Kingston College of Nursing and Midwifery/NESCOT, the information describing the qualities of the graduate is separated into six individual statements. The second statement lists 10 measurable skills required of a midwife, and the third requires that the midwife demonstrates the educational

outcomes cited in the Handbook of Midwives Rules, Rule 33 (March, 1991). These rules are listed under 11 outcomes of midwifery education. Both statements are extensive and are included in Appendix 2.

Both programs, when describing the graduate qualities talk about, independent, self-directed, self-motivated, self-reflective, self-evaluative, accountable, critical thinkers who are intuitive, creating and influencing the future of nursing practice by responding to and anticipating the changing needs of society.

#### **Criterion 3.b) Structure of the Knowledge Base**

Bevis (1989) describes some examples of the source of knowledge base as the traditional ways of viewing and grouping content: the known cognitive, semantic maps; the conceptual constructs, concepts, propositions, theories and values of nursing both in their present state and in their future possibilities; and in the sanctioned ways of inquiry (p.146).

#### **The University of Victoria - The Collaborative Nursing**

Program curriculum is based on a philosophy that:

reflects a commitment to implement a humanistic phenomenological and socially critical curriculum which considers the changing health care needs of our society.

Emerging from the philosophy is, what the program describes as, the "metaconcept" of caring. Caring is understood as the attitude and activity of nursing and is considered in every nursing course. Caring reflects the

theories of Watson (1988); Benner (1984,1989); Leininger (1981), and others and capture the notion that caring encompasses moral, ethical, aesthetic, theoretical and practical nursing care. Bevis explains that caring is not a soft and sympathetic notion, but rather a driving force which compels nurses to act ethically and justly. The entire curriculum is based on Bevis and Watson's (1989) conceptualization of a caring curriculum for nurses.

Emerging from this philosophical orientation is a health perspective that gives direction to the actualization of the curriculum. This perspective acknowledges the need for socio-ecological perspective with a multidisciplinary focus. Health is viewed as a resource that is not owned solely by health care professionals, communities or clients. The pursuit of health is viewed as a partnership and concepts such as empowerment, responsibility, perception, choice, advocacy, hardiness, self-help and vulnerability are explored throughout the program. The shift in focus from illness to health, represents a deliberate move away from a medical model to a health promotion perspective; an understanding that nurses' work focuses on people and their experiences with health and the healing process. Learners examine the challenges to health, people's experiences of the challenges and mobilization of the resources to deal with the challenges. Also incorporated into this model are innovative teaching methodologies, e.g., to encourage the development of

critical thinking, discovery of personal meaning and empowerment.

Consistent with a health promotion perspective and nursing focus, four themes have been identified to provide an organizing framework. These themes are defined as follows:

- a) people's experiences with health - a process whereby people realize aspirations, satisfy needs and change or cope with their environment.
- b) people's experiences with healing - a process of becoming increasingly whole. It is a totally organismic, synergistic response that emerges from within the individual if recovery and growth are to be accomplished.
- c) people's experience with self and others - the process by which people come to understand the meaning an experience has for themselves and others. The way we relate is through self knowledge, which comes through reflection, introspection and interaction, which results in the discovery of personal meaning.
- d) people's experience with professional growth - The process by which nurses make a difference at a personal, professional, social and universal level.

Four critical concepts act as threads to weave the metaconcepts of caring with the four concept themes, and are integral to every nursing course. The critical concepts are: ways of knowing, personal meaning, time/transitions and context.

The concept of ways of knowing is based on the work of Carper (1978); Belenky, Clinchy Goldberger and Tarule (1989); Benner (1984); Tanner (1990) and stresses the importance of many different ways of knowing from a theoretical, practical, aesthetic and ethical perspective.

The need for nurses to derive personal meaning from their learning is the second concept and is based primarily

on the work of Combs (1982) and Meizerow (1990), in which learning occurs on the personal meaning people attribute to their experiences.

The concept of time/transitions encompasses the work of Chick and Meleis (1986), Newman (1982), and Watson (1988), in which people are considered to be constantly in a state of transition from one state to another (e.g., becoming a mother) and each transition must be acknowledged and incorporated into the care of the client. Time incorporates the notion that people are historically placed, and that nurses care for clients throughout the lifespan.

The concept of context takes into consideration both the environmental factors, as well as cultural factors that influence and affect client care. This includes the phenomenological notion of "situatedness", described by Fonow & Cook (1991) as "a feminist approach to research, characterized by an emphasis on creativity, spontaneity and improvisation....to use already given situations both as a focus of investigation and as a means of collecting data" (p.11). Sensitivity to context also includes awareness to ethnic and cultural variance.

The concept of praxis is another unique feature of the Collaborative Nursing Program; the emphasis on clinical experience as a foundation of nursing theory and the recognition that nurses' work requires thoughtful, reflective action. To assist in actualizing the concept of praxis, consolidated clinical experiences are integrated throughout



the program of studies.

Kwantlen University College. The present Diploma Nursing Program, an adaptation of the curriculum developed at Mohawk College, Hamilton, Ontario, is a nursing education program completed by students in two years of full time, or four years of part time study. The concepts of the curriculum framework are derived from three sources: 1. philosophy of the program, 2. the terminal objectives, and 3. the Roy Adaptation Model of nursing (1976, 1984) and are integral to the program.

The philosophy of the Diploma Nursing Program was developed by the faculty and provides the foundation for the program, used to give direction to the planning and implementation of all learning experiences. It describes the beliefs held by the faculty about people, health, nursing, learners and learning and nursing education.

The terminal objectives, as well as describing the expected abilities of the program graduates, are the eight criteria used to evaluate the students throughout the program. The terminal objectives are:

1. Apply knowledge from the sciences, humanities and nursing in nursing practice.
2. Use the nursing process to promote adaptation of clients with varying degrees of health and illness.
3. Communicate effectively with clients, families and members of the health care team.
4. Perform psychomotor skills safely ensuring the client's physical and psychological comfort.
5. Use principles of teaching and learning to promote adaptation of clients.

6. Demonstrate accountability and responsibility in nursing practice.
7. Demonstrate organizational ability in the provision of nursing care.
8. Work collaboratively with members of the health care team.

The Roy Adaptation Model is introduced in the first nursing theory course and is used throughout the program to organize content and to provide a framework for clinical practice.

The organizing concepts of the Kwantlen curriculum provide the rationale where the three major concepts are classified according to whether they help unify or level content. Unifying concepts are defined as those which are used throughout the program and help the student to integrate content. For example, the Roy Adaptation Model, nursing process and the terminal objectives are considered to be unifying concepts.

Levelling concepts are defined as those which require progressive learning throughout the program, building from simple to complex. The major concepts which level the program are: 1.health-illness continuum; 2.adaptation, and 3.collaboration with the health care team, all of which increase in complexity as the student moves through the program. The curriculum is divided into three levels, based on the levelling concepts. The levels do not correspond to any academic or calendar year. At each level there are objectives which the student must achieve before progressing to the next level.

The major concepts of the nursing curriculum are used to organize and sequence content within the 13 nursing theory and clinical courses. The nursing theory courses are modularized and self-directed, subdivided once again into smaller learning units called learning packages. These contain learning objectives, learning activities, resources and self-assessment tests.

Ontario Universities Consortium (Laurentian, McMaster and Ryerson Polytechnic University) is a direct-entry midwifery program leading to a Bachelor of Health Sciences (B.H.Sc) in Midwifery. The curriculum does not identify a theoretical framework, and is structured around the philosophy of the program. This is based on the International Definition of a Midwife, and reflects the philosophy of midwifery in Ontario and its focus on women's participation in their health care. The guiding principles of midwifery education, included in the curriculum documents, give further insight into the philosophical framework of midwifery education.

The concepts of holistic care and continuity of care are referred to constantly throughout the curriculum document, and although not identified as such, these two concepts run integral to the program. Continuity, as a concept, is also inclusive of student/clinical preceptor supervision.

The curriculum plan and the course descriptions outline the content and topics in two plans. Plan A, subdivided into three levels, sets out a three year program of full time

study. Students enrolled in a program of part-time study follow an alternate curriculum and an example Plan B (a five year, 14 term program), is used to illustrate a possible part-time course sequence. The course sequence moves from foundation courses, to the application of knowledge in clinical practice and example plan B is listed below.

**PLAN B (Possible Part-time Sequence)**

**YEAR 1**

**Introduction to Midwifery (+)**

**Term 1**

**Social and Cultural Dimensions of Health Care 1  
Women's Studies**

**Term 2**

**Introduction to Midwifery (contd)  
Social and Cultural Dimensions of Health Care 2  
Women's Studies (contd)**

**Term 3**

**Midwifery Care 1 (\*)**

**YEAR 2 - Term 4**

**Topics in Biological Science 1  
Critical Appraisal of Research Literature**

**Term 5**

**Topics in Biological Science 2  
Elective**

**Term 6**

**Midwifery Care 2 (+)**

**YEAR 3 - Term 7**

**Midwifery Care 3 (\*)  
Clinical Placement 1**

**Term 8**

**Reproductive Physiology  
Elective**

**Term 9**

**Health, Science and Society  
Social Science or Women's Studies (choice)  
Elective**

**YEAR 4 - Term 10**  
**Midwifery Care 4 (\*)**  
**Clinical Placement 2**

**Term 11**  
**Principles and Methods of Research**  
**Health Education and Health Promotion**

**Term 12**  
**Midwifery Care 5 (\*)**  
**Clinical Placement 3**

**YEAR 5 - Term 13**  
**Midwifery Care Clerkship (\*)**

**Term 14**  
**Professional Issues**  
**Final Synthesis Paper**

(+) Includes a week when all students are brought together in one site.

(\*) Clinical course consists of a placement in a practice and concurrent problem-based tutorials that span antenatal, intrapartum, postnatal and newborn care.

**Epsom and Kingston College of Nursing and Midwifery in collaboration with North East Surrey College of Technology.**

This is a post-registration program for registered nurses, leading to Registered Midwife Diploma in Higher Education (Midwifery). The curriculum framework is based on three models: 1. objectives model, 2. process model and 3. spiral curriculum model.

The objectives model (Tyler, 1949) provides the rationale in respect of demonstrating the activities and educational outcomes as described in Rule 33, Midwives Rules (UKCC, March 1991), and meeting the requirements of EEC directives.

See Appendix 2 for the measurable activities of midwifery education/Rule 33 Midwives Rules.

The English collaborative partners acknowledge that the use of a behavioral objectives model alone has educational limitations, according to critics it has been seen as dehumanizing, and inhibiting creativity (Elias & Merriam, 1984, p.96). Professional skills continue to develop and change after qualifications and it is necessary to recognize the need to nurture the enquiring mind and facilitate strategies that enable students to continue their education after registration. This is in accordance with the UKCC Code of Professional Conduct and Midwives Rules. Therefore the concept of education as a continual process is acknowledged in the English curriculum and is described in the philosophy of the process model (Stenhouse, 1975).

Embracing both models is a spiral curriculum (Bruner, 1966), which allows the subject to be examined and for learning to be facilitated in a simple form and successively revisited in greater depth and complexity as the student progresses through the course of studies. The program is divided into two Parts. Part 1 consists of three Units and Part 2 consists of two Units. The program progresses from a foundational knowledge in Unit one, to the reflective practitioner in Unit five. The spiral curriculum (Bruner, 1966) allows the student a backward and forward movement; to revisit and clarify knowledge.

An essential reading list is provided with each unit, and students are encouraged to explore and develop their own potential by utilizing appropriate learning experiences/

methods, using a clinical diary and completing a continuous assessment strategy. Formative and summative assessment are also described in length by the English consortium.

Criteria 3.g) and 3.h), Interests/Choices of the Students and Fields and Disciplines contributing to Nursing, are dealt with together in this section to avoid repetition.

In Criterion 3.g) Bevis (1989) describes students as "the soul of the curriculum" and in order to be responsive to the uniqueness and liberation of the individual, the content must reflect the individuality of need, freedom of choice and pursuit of private goals (p.148).

Criterion 3.h) According to Bevis (1989) many fields have an influence on nursing curriculum content. Philosophy, the humanities, history, psychology, physiology, sociology and anthropology and all other social sciences affect, and are in turn, affected by nursing. Nursing is "more than the pure sciences" (p.148) and therefore nursing education must bring together knowledge from the social sciences and humanities within its knowledge base and practice (p.148).

The four selected curricula, include courses from other disciplines within their programs, allowing student choice, by incorporating elective courses within the theoretical framework. Psychology and sociology dominate the four curricula as compulsory non-nursing, non-midwifery courses. For example, Kwantlen University College requires that the student complete six co-requisite, non-nursing courses: four

compulsory courses and two elective courses. Along with biology and English, the compulsory courses include psychology and sociology, whereas the student has freedom to follow individual choice and interest for the two remaining elective courses. This is similarly reflected within the theoretical content of the remaining three curricula.

The four curricula are unanimous regarding student individuality, freedom of choice and pursuit of personal goals. I was interested to discover which disciplines were popular with students, given the freedom of choice in elective course selection. Kwantlen University College provided the insight, and emphasis seems to be in the humanities and social sciences, although computing courses and biology courses are also popular. The elective courses in the humanities and social sciences usually include courses in sociology, psychology at the 200/300 level, and anthropology at the 100 level are popular choices. Examples of these courses are: Sociology 240-Women in Canada, Sociology 280 Sociology of Health and Illness, Psychology 320 Developmental Psychology: Childhood, and Anthropology 100 Social and Cultural Anthropology (Zoe Johnston, Personal communication, 1995). The University of Victoria describe their electives or support courses as "packages" and the student has a choice between sociology, anthropology or psychology.

Other topics discussed and acknowledged within the four curricula, and presented either as compulsory courses or encouraged as electives, are courses dealing with the



feminist impact on nursing and midwifery from a social and historical perspective, philosophy, anthropology, ethics and the law. Research is also emphasized in the four curricula in the form of directed readings, research projects or special studies in a specified area of student interest.

Criteria 3.c) and 3.e) the Culture of the Field and the Needs of Nursing are examined together to avoid repetition.

Criterion 3.c) The culture of the field and its relationship to the culture of society in which it exists, and Criterion 3.e) needs of nursing where content helps graduates to advance nursing in order to better fulfill its societal role; to advance nursing in ways that are responsive to the caring needs of people, are essential parts of the professional curriculum (Bevis 1989).

The four curricula meet both criteria. They all place emphasis on their respective professional positions, their historical origins and development, within the society in which their programs' exist. The curricula from the two midwifery programs (Ontario Universities Consortium, Epsom and Kingston College of Nursing and Midwifery/NESCOT) reflect the criteria within their respective position statements and theoretical curriculum content. The English consortium, in a section devoted to the Development of the Program and the Development of the Existing Curriculum, explain why, and how they changed from the previous curriculum that was presented by the three agencies, in isolation of each other.

The professional guidelines changed in 1987 (English National Board Circular, 1987/28/MAT) allowing more flexibility with curriculum design. The consortium was formed and after a great deal of research and program appraisal, and also mindful of the factors that influenced the curriculum, such as the desires of the consumer and the profession, as well as a changing political scene, the present program was developed. The English consortium acknowledges that midwifery is a practise-based profession, that qualification and competency is dependent on meeting EEC directives and requirements of the statutory body, and this is reflected throughout the theoretical content of the curriculum.

In Ontario the picture was similar to England, with one major difference, midwifery was emerging as a new health care profession. The Midwives Act was enacted in 1991, after years of consumer and professional lobbying, to legally recognize midwifery as a profession in its own right. The Ontario Universities Consortium was formed with the provincial government approval. The consortiums' Statement of Beliefs clearly defines their position regarding both criteria 3.c) and e) and these six beliefs are reflected throughout the theoretical content of the curriculum. Examples of the statements are:

We believe that midwifery has the potential to be one of the most important components of women's health in Ontario.....

We believe that midwives are the best persons to teach the professional practice of midwifery....the educational program has a special responsibility to

foster partnerships between midwives and other health care providers for the benefit of students and women who seek midwifery care.

We believe the educational program is an integral part of the evolution of the profession of midwifery in Ontario and Canada....must help create future leaders and teachers.

The two nursing curricula, University of Victoria and Kwantlen University College are clearly orientated, in their program philosophies, to criteria 3.c) and e) and this is reflected in the theoretical content of the respective programs. The two nursing programs have extensive program philosophies and both discuss the role of nursing in terms of caring, "the professionalization of the human capacity to care" (Collaborative Nursing Curriculum, p.7). Nurses are in a unique position to help people understand their health related experiences and to embrace their ability to make informed health care choices. Through caring relationships, nurses inform, involve and empower i.e., to inform, educate and support the informed decision of their clients in health choices, enhancing the healing process. Northouse and Northouse(1992) describe professional-patient relationships as "one of the most crucial components of the health care delivery process" (p.74) and discuss how these relationships can be moved from a position of patient dependency by effective communication.

The four curricula place emphasis on conducting and utilizing research, professional growth, accountability to their professions' standards and ethics, and to strengthening the mandate of nursing and midwifery respectively. Although

all the programs discuss professional development in general terms, the English and Ontario consortiums, devote a section of their curricula specifically to professional and faculty development.

Criteria 3.d) and 3.f) The two criterion are closely associated in content, and therefore will be examined together to avoid repetition. Criterion 3.d) In Needs of Society, Bevis (1989) states that nursing must continually attune to the problems, issues, trends and needs of the society it serves and that the curriculum content must respond, by educating nurses who can give transpolitical care i.e care that transcends political ideologies, that has moral commitment. In Criterion 3.f) Health Problems, Bevis (1989) states that curriculum must reflect with health problems that nurses will be called upon to face in the foreseeable future (p.146-147); to graduate professionals who are committed to a whole range of possibilities, from national policy setting to patient care.

The four curricula all meet the specifics of criteria 3.d) and f). The philosophy statements from the two nursing programs, the Collaborative Nursing Program and Kwantlen University College, clearly define the person/individual, health care/services and both philosophies are in accord with the World Health Organization definition of health:

(Health is) the extent to which an individual is able, on the one hand, to realize aspirations and satisfy needs and on the other hand, to change or cope with the environment....a resource for everyday life, not the

object of living....a positive concept emphasizing social and personal resources as well as physical capacities (World Health Organization,1984).

The Collaborative Nursing Program shifts the nursing curriculum and orientation, from a biomedical technocure model, to a health and healing model using people's experience as a framework to guide nursing care. Kwantlens' curriculum and theoretical core reflects the needs of society and the rights of individuals. They state that health and illness are individually and culturally defined and that individuals have the right for equal access to available health services, regardless of age, gender, beliefs, ethnic origin, socio-economic status, or state of health.

The right to health care for all is highly valued by our society and this position is supported by the Canadian nursing profession. Both nursing programs claim to educate graduates to assume a professional commitment to health and the well-being of clients, and in accord with the Canadian Nurses Association, Code of Ethics for Nursing (1991), the two nursing programs support such concepts as: advocacy of interests of clients, the community and society, dignity, respect, choice, cooperation, and these values are reflected in the theoretical components of both curriculum.

The Collaborative Nursing Program, discussing the complex and changing nature of health care, states that, Nurses have a vital role to play in shaping and responding to the challenges of health care in our society. Nurses must

strengthen their mandate and their ability to promote health through continuous professional growth.

The two midwifery programs, Ontario Universities Consortium and Epsom and Kingston College of Nursing and Midwifery/NESCOT parallel the position of the two nursing programs. They discuss holistic care, consumer rights and choice, advocacy, cooperation, ethnic/cultural/minority awareness, an awareness of the political, economic, social, and the technological environment, all of which are reflected in the theoretical components of their curricula.

In summary, the thesis purpose has been to examine the four selected nursing and midwifery programs, to identify the educational philosophies and theoretical content common to the programs. The four programs have an identified common ground in their educational philosophies, combining the traditional curriculum within a humanistic framework while the common theoretical content is listed in more detail in Chapter Four (see p.114). The common theoretical content identified in the descriptive comparison is extensive and combined with the educational philosophies common to the four programs, is sufficient to explore a framework for a common fundamental curriculum for nursing and midwifery.

## Chapter Four

### The Framework for a Collaborative Fundamental Curriculum for Nursing and Midwifery Education Programs

The common philosophical and theoretical curriculum content, identified by the descriptive comparison in Chapter 3, will be outlined in this chapter.

The educational philosophies that form the foundational basis of the collaborative fundamental curriculum framework are presented, beginning with the influence of traditional quantitative/behaviorist theory on nursing and midwifery education programs and followed by humanistic education theory and principles.

Humanistic principles, with the emphasis on the learner and learning and the subsequent change in the role of the teacher within this paradigm, are combined with the concepts of androgogy, the adult learner, and basic encounter groups. as a components of humanistic adult education.

Finally, a framework for a collaborative fundamental curriculum for nursing and midwifery education programs will be discussed.

#### The Influences of Behaviorist Theory in Nursing and Midwifery Education Programs.

Elias and Merriam (1984) observe that "Probably no other system of psychology has had as much impact on general and

adult education, or had its principles be the cause of as much debate as behaviorism" (p.79). Behaviorism, ordinarily considered to be a psychological system, focuses on the observable behavior of an organism.

For many years, behaviorist principles have had a major impact on adult education curriculum design and program development. Behaviorist education philosophy, advocates measurable change in the learner's behavior. Learning in behavioral terms, is a change in behavior (Elias and Merriam,1984; Bevis,1989). This is achieved by means of behavioral or "instructional" objectives. Elias and Merriam (1984) describe these objectives as conditions, behavior and criteria.

1. the relevant *conditions* or stimuli under which a student is expected to perform;
2. the *behavior* a student is to perform including a general reference to the product of the student's behavior;
3. a description of the *criteria* by which the behavior will be judged acceptable or unacceptable, successful or unsuccessful. (p.89)

Most of the education/training programs in the health sciences in Canada have thus far mainly subscribed to a Tylerian behaviorist curriculum. This philosophy embracing competency-based education;outcome rather than the process of learning, is well suited in certain settings and has been implemented for many years by colleges and educational agencies.

The Tyler model, based on behavioral objectives, has according to Bevis (1989), "enjoyed a 35 year reign without



competition" (p.29), and is the model that has become mandatory practice for schools of nursing and midwifery. Elias and Merriam (1980, p.95-102) state that "behaviorism has had its greatest impact in adult education in curriculum design and program development" (p.99) and "while no single individual can be singled out as the major proponent of this philosophical orientation, Tyler can be credited as having a major influence on the program development models proposed by Houle, Knowles and others" (p.99-100).

In "Basic Principles of Curriculum and Instruction", Tyler (1949) states that "Education is a process of changing the behavior patterns of people" (p.5). According to the Tyler paradigm, the curriculum planner needs to ask four fundamental questions:

1. What educational purposes should the school seek to attain?
2. What educational experiences can be provided that are likely to attain these purposes?
3. How can these educational experiences be effectively organized?
4. How can we (*the school*) determine whether these purposes are being attained? (Tyler, 1949, p.1)

According to Tyler, objectives can be derived from three sources; the students, the society, and the subject matter. Once these tentative objectives are screened through the accepted faculty philosophy and a learning psychology, a refined list of objectives remains, which are then stated in the form of teaching, learning experiences that reflect the

changes required in the student's behavior (Bevis, 1989, p.24).

All the selected learning experiences and including the evaluation process reflect the major objectives of the program. As Tyler (1949) observes of the evaluation process "The process of evaluation begins with the objectives of the educational program" (p.110).

This model also has ramifications for the teacher. When content flows from behaviorally stated objectives, what to teach becomes more important than how to teach. Faculty energy becomes absorbed in the curriculum and course content, and according to Bevis (1989) the teacher's relationship "to the objectives then becomes an intimate one, in that failure of students to achieve those objectives becomes a failure in teaching" (p.137).

The Tyler model has maintained such a powerful hold on nursing programs until recently, that it was also the standard for accreditation of nursing schools in the United States. As Bevis (1989) observes the "Tyler-type, curriculum development products have also been translated into essential components" for nursing education accreditation and approval process (p.28).

Present nursing values are in a state of change and until recently "nursing's dominant educational ideology was viewed as a neutral technical process, associated with biomedical science empiricism and a set of tasks and functions" (Moccia 1988 in Bevis and Watson 1989 p.38);

"void of human meaning and values" (Greene 1988 in Bevis and Watson 1989 p. 38); "void of moral commitment, intentions, goals and moral ideas or the covenantal relationship associated with human caring (healing and wholeness)" (Gadlow, 1988 in Bevis and Watson 1989 p.38).

Bevis (1989) states that "Behaviorism can produce efficient nurses on a technical level. The long, successful use of behavioral objectives has proven this beyond any doubt" (p.32). One could also argue the same case for many established midwifery programs when the technical aspects of the "job" of midwifery are considered, where objectives can be measured.

Tyler-type models certainly have qualities to commend them, especially in the "training" aspects of nursing and midwifery practice. Behavioral objectives represent minimal achievement levels (Bevis,1989) where the objective of the learning situation is to meet the standard of the behavioral objective. They are useful for the instruction and measurement of technical skills such as giving an injection, catheterization, abdominal palpation, or the psychomotor skills necessary to assist the birth of a child. As Bevis (1989) observes "all generic nursing education....has some content that lends itself to behaviorism regardless of level" (p.30).

However it is the belief of humanistic theorists' that behavioral objectives, if used exclusively in the curriculum,

become inhibitors of achievement and creativity. As Watson observes:

Teaching mostly the rules and procedures - the "trim" of nursing does not lead to understanding people and how they cope with health and illness. Even if the rules and procedures could be taught (they cannot), many things taught today are outdated in a few years. (Watson, (1988) in Bevis and Watson,1989, Towards a Caring Curriculum - A New Pedagogy for Nursing, p.31)

Group sharing, understanding, caring, loving, compassion, pain, hope, suffering, wonder and excitement as human experiences cannot be measured by a behaviorist orientated curriculum. Bevis (1989) states that what is needed for nursing, and indeed one could argue the same for midwifery education, is a "legitimization of the practical elements and aspects of curriculum; an endorsement of the dynamic, creative whole of education....the teaching of inquiry, reflection, criticism and caring inclusive of all aspects of nursing education - planned, prescribed, accidental, individual, public and private" (p.33).

I believe that behavioral objectives do have their place in the curricula of nursing and midwifery, and can be used to teach the training, psychomotor components of nursing and midwifery, and if combined in a curriculum that also values humanistic philosophical concepts, without stifling the inquisitive, creative aspects of education.

#### **An Introduction to Humanistic Adult Education Principles.**

Elias and Merriam (1984) state that "Humanism is a broad philosophical point of view that holds sacred the dignity and

autonomy of human beings" (p.109). The goal of humanistic education is the development of persons who strive for self-actualization, are open to change; life long learners who can live together as fully-functioning individuals.

Unlike behaviorist education, where all human behavior is believed to be the result of prior conditioning and determined by external environmental forces over which there is little or no control, humanistic educators believe that motivation for learning is intrinsic and emanates from the learner. Therefore humanistic education focuses upon the learner, rather than the body of information.

According to Maslow, the goal of education is to foster the self-actualized person, "helping the person to become the best he is able to become" (Maslow, 1976, in Elias and Merriam, 1984, p.123). Maslow described the personality characteristics of the self-actualized person as:

- they are realistically orientated
- they accept themselves, other people, and the natural world for what they are
- they are spontaneous in thinking, emotions, and behavior
- they are problem-centered rather than self-centered in the sense of being able to devote their attention to a task, duty, or mission that seems cut out for them
- they have a need for privacy and even seek it out on occasion, needing it for periods of intense concentration on subjects of interest to them
- they are autonomous, independent, and able to remain true to themselves in the face of rejection or unpopularity
- they have a continuous freshness of appreciation and capacity to stand in awe again and again of the basic goods of life, a sunset, a flower, a baby, a melody, a person
- they have frequent "mystic" or "oceanic" experiences although not necessarily religious in character
- they feel a sense of identification with mankind as a whole in the sense of being concerned not only with the lot of their immediate families, but with the welfare of

the world as a whole

- their intimate relationships with a few specifically loved people tend to be profound and deeply emotional rather than superficial
  - they have democratic character structure in the sense of judging people and being friendly not on the basis of race, status, religion but rather on the basis of who other people are as individuals
  - they have a highly developed sense of ethics
  - they resist total conformity to culture
- (Maslow,1954, in Elias and Merriam, 1984,p.124).

Rogers (1969) describes the self-actualized person as the fully-functioning person:

is able to experience all of his feelings, and is afraid of none of his feelings; he is his own sifter of evidence from all sources; he is completely engaged in the process of being and becoming himself, and thus discovers that he is soundly and realistically social; he lives completely in this moment, but learns that this is the soundest living for all time. He is a fully functioning organism, and because of the awareness of himself which flows freely in and through his experiences, he is a fully functioning person.  
(Rogers,1969, in Elias and Merriam, 1984, p.124)

### The Learner and Learning

In humanistic education, behavioral objectives no longer drive the curriculum. Bevis (1989) maintains that behavioral objectives are "antithetical to liberating education" (p.138). Elias and Merriam (1984) state that "An equally valued source of curriculum is the examination of one's own values, attitudes and emotions" (p.128). The curriculum then, becomes a vehicle for the prime goal of humanistic education, that of developing the self-actualizing person. Bevis(1989) defines curriculum as "those transactions and interactions that take place between students and teachers, and among students with the intent that learning take place" (p.72)

Learning is viewed as a highly personal individualized process in humanistic education and Rogers (1969) suggests the discrepancy between the "real" and the "ideal" self is the stimulus to learning (Elias and Merriam,1984,p.126).

Rogers (1969) describes meaningful learning as "experiential" learning and states that the only significant type of learning is where the whole, complete person is involved in the process, when there is personal involvement of both the feeling and the cognitive person. Where a sense of reaching out, a sense of discovery and comprehending comes from within; where learning is pervasive and can be evaluated by the learner, changing attitudes and behavior that meet the needs, as well as holding personal meaning for the learner (p.5).

While many of Rogers theories have been popularized to education in general, Knowles (1970) attempted to define humanistic education "into a theoretical framework for adults" (Elias and Merriam,1984, p.131). Knowles proposed the word *androgogy* to characterize adult education. Knowles(1970) states that androgogy is based on four crucial assumptions about the characteristics of the learner that differ from the basic assumptions of traditional pedagogy.

These assumptions are that as individuals mature:

- 1) their self-concept moves from one of being a dependent personality towards being a self-directed human being;
- 2) they accumulate a growing reservoir of experience that becomes an increasingly rich resource for learning;

- 3) their readiness to learn becomes orientated increasingly to the developmental tasks of their social roles;
- 4) their time perspective changes to one of postponed application of knowledge to immediacy of application and accordingly their orientation towards learning to one of subject centeredness to one of performance centeredness (Knowles,1970,p.45).

Androgogy also incorporates other basic humanistic principles such as self-diagnosed learning, self-evaluation, a cooperative rather than a competitive atmosphere, as well as respect and trust for the adult learner. To Knowles, the learning process involves the whole person, emotional, psychological and intellectual(Elias and Merriam,1984,p.133).

#### **The Teacher as Facilitator**

Traditionally the process of curriculum development within the health care disciplines has been linear in nature. and while linear models can provide help within their conceptual framework for "training" according to Bevis (1989) they can also be "dangerously limiting by dictating the constraints that restrict exploration of new ideas about ways to approach nursing teaching" (Bevis, 1989, p.109).

With the humanistic emphasis upon the learner, it necessarily changes the function of the teacher, from provider of information, to that of "facilitator, helper and partner in the learning process" (Elias and Merriam, 1984, p.125). Rogers (1969) discusses the accepted definition of traditional teaching as "to instruct", "to impart knowledge" "to make know" (p.103). He goes on to say that this type of instruction "makes sense in an unchanged environment"(p.104)



but that in fact humankind lives in a constantly changing world where technological advances are increasing knowledge rapidly and that the goal of education should therefore be the "facilitation of change and learning" (p.104).

Fluidity and interconnectedness between the Clusters of Influence (Bevis, 1989) is clearly demonstrated between the Faculty Development and the General Goals/Ends-in-View Cluster. Both clusters have a major impact on each other if substantive curriculum change from behavioral objectives and linear models is to occur. Changes that require faculty role change, changed perceptions in curriculum alliance and an increased tolerance of ambiguity.

Bevis states that the Faculty Development Cluster "is the key to the substantive differences between this paradigm and a behaviorist one" (Bevis, 1989, p.110). It represents a major change from the traditional teaching methods and ways of viewing the curriculum. The primary goal is a change in the teacher role and Bevis suggests that without this role change, the curriculum will remain unchanged, packed with "a thousand diseases" (p.110), and that learning will remain defined in terms of behavioral changes.

Bevis (1989) states that within the paradigm of "curriculum as interaction" (p.164), the teacher becomes an expert learner, whose main purpose is to support the student as a novice learner; "to provide the climate, the structure, and the dialogue that promote praxis" (p.173).

In the General Goals or Ends-in-View Cluster, Bevis (1989) rejects behavioral objectives, except in relationship to technical skill trainings (p.137) and suggests instead general goals or ends-in-view to point direction without dictating specific curriculum content. She suggests "criteria" as guides to curriculum development; "criteria for teacher-student interactions and criteria for selecting or developing learning experiences" (p.138). Bevis acknowledges that the criteria, pointing direction without dictating specific content, can cause uncertainty and ambiguity for faculty.

Within the educative-caring paradigm described by Bevis (1989), the traditional power structure within the classroom is democratically deployed. Teacher authority is redirected into designing and selecting learning activities that facilitate faculty/student, student/student interactions supportive of learner maturity and accessing educative learning that is both emancipating and liberating. Within this cluster, *how to teach* becomes more important than *what to teach*.

Rogers (1969) suggests the quality of "realness" to the effective facilitator. The facilitator should be real enough to own their own feelings whether anger, enthusiasm, interest or plain boredom (p.108). Rogers (1969) maintains that prizing, acceptance, trust and empathetic understanding are also other qualities of the successful facilitator (p.112).

Conversely, Rogers (1969) suggests that the effect upon the instructor, in an environment of significant, personal-learning, is that they are also changed. No longer the teacher but "catalyzers", giving freedom and life and the learning opportunities to students (p.126).

In the publication Women's Ways of Knowing - The Development of Self, Voice and Mind, Belenky, Clinchy, Goldberger and Tarule (1986) discuss what they describe as connected classes and connected teaching. Belenky et.al. state that "Connected teachers are believers. They trust their students thinking and encourage them to expand it" (p.227), and are ones who "support their students thinking, but do not do the students' thinking for them or expect the students to think as they do" (p.218).

The concept of the "basic encounter group" is another component of humanistic adult education and lays emphasis on cooperation as a means of maintaining democracy (Elias and Merriam,1984). According to Elias and Merriam (1984), many education theorists subscribe to the notion that the best way to foster growth and cooperation is through group learning, and this type of instruction is by no means new to education. They state that "Dewey and other progressive educators.... gave their support to group activities as a means of learning and preserving democratic ideas" (p.129).

Rogers (1969) states that "the goal of education must be to develop a society in which people can live more comfortably with change than rigidity" (p.304). He believes

that one of the most effective tools for educational growth, understanding and change is the intensive group experience.

Rogers is considered to be the founder of group learning, termed by him as "basic encounter group". The encounter group (popularized in the 1960s) is primarily an adult education activity and has brought together people from varied backgrounds for the purpose of experiencing and interacting with each other. Learning experiences within the encounter group vary, but overall the purpose is for a direct approach to promote effective interaction and growth.

Patterson listed the possible learning outcomes of encounter group experiences as:

- to listen to others
- to accept and respect others
- to understand others
- to identify and to become aware of feelings
- to express one's own feelings
- to become aware of the feelings of others
- to experience being listened to by others
- to experience being accepted and respected by others
- to experience being understood by others
- to recognize the basic commonalties of human experience
- to explore oneself
- to develop greater awareness of oneself
- to be oneself
- to change oneself in the direction of being more the self one wants to be. (Patterson, 1973, in Elias and Merriam, Philosophical Foundations of Adult Education, 1984, p.130)

Rogers (1969) suggests the use of basic encounter groups for the education of administrators, teachers and students i.e. peers or near peers in separate groups. He also maintains that vertical groups should be attempted to bring together members of the separate groups. Rogers cautions that this should be initiated in a non-threatening manner but that such

a group would bring about greater understanding of self and other members (p.317).

Northouse and Northouse (1992) report some of the innovative uses of encounter group activity already initiated between the health care professions to promote inter-professional understanding and to increase role knowledge (p.92). Sharing common core courses during educational experiences, increased contact between professions during clinical rotation are reported by Weinberger, Green and Mamlin (1980); Williams and Williams (1982) and interdisciplinary seminars reported by Balassone (1981).

The implications of the above notions reported by Northouse and Northouse (1992) for nursing and midwifery education are infinite. Initiating such an innovative method as basic encounter groups within a collaborative fundamental curriculum framework could promote the eradication of long held misconceptions, held by both groups.

Rogers (1969) does acknowledge the negative side to the basic encounter groups, administrators who fear "too much change" or the possibility of rejection by the community who may fear freedom of thought, choice or action and have rigid views about what a college or university should be (p.318). Talking with midwives, I found that they fear the loss of autonomy and independence if an alliance was formed with nursing. It is however the opinion of this author that professional strength can be the product of educational interaction between the two professions. Basic encounter

groups within a collaborative fundamental curriculum can promote interaction, idea sharing and interprofessional understanding, not for the purpose of removing autonomy and independence from either profession, but by allowing both sides to hear and be heard as equal members of the health care team.

### **Common Content Data from the Descriptive Comparison**

The following section is limited to the philosophical framework and the theoretical content, common to the curricula of the four selected programs.

#### **1. Common Philosophical Framework**

For many years, competency based education has dominated the curricula of health education programs. Certainly the curricula for nursing education has reflected a heavy behaviorist influence. Nursing educators are now calling for a more qualitative/humanistic type of *education* rather than the primarily quantitative/behaviorist approach associated with the notion of *training*; a curriculum that values the individual, reflects the needs of adult learners, and encourages creativity. Midwifery philosophy also places value on the autonomy and dignity of the individual and is therefore compatible with a humanist philosophy.

The four selected programs integrate the theories of behaviorist and humanistic adult education principles within the philosophical framework of their curricula. The traditional curriculum is confined to the "training" aspect

of nursing and midwifery. I had expected more emphasis on the traditional curriculum, especially in the English program, but this is not the case.

The educational philosophies are reflected in how specific content is taught to the student; whether the content is taught by behavioral training methods or by what Bevis (1989) describes as the "educative learning"(p.32) of humanistic educational principles. Certain components of nursing and midwifery education lend themselves to the technical training of behaviorism while other curriculum components are better suited to the principles of humanistic adult education, where curriculum as is viewed as interaction "with the intent that learning take place" (Bevis,1989,p.72).

It is not the intention of this thesis to dismiss the Tyler-type curriculum as passe, in fact, I support a program that acknowledges and combines both conceptual frameworks and philosophies within its curriculum. I think that behavioral objectives should be employed when teaching the technical, psychomotor aspects of the "job" of nursing and midwifery, as a means of evaluating student understanding of the critical elements in any given procedure, vital to maintaining client safety. Techniques such as the administration of an injection or the psychomotor skills required when delivering and resuscitating an infant can be taught and minimum standards of competence be evaluated by the use of behavioral objectives. However within the behaviorist/quantitative paradigm, meeting the minimum standards of the objectives

becomes the primary purpose, leaving little room for idea sharing and dialogue.

Humanistic adult education philosophy, supporting the "education" aspect of a liberal arts education, predominates in the four selected curricula, and this in turn is reflected throughout the descriptive comparison. While adult education principles are integral to the four curricula, the English consortium specifically emphasize androgogy within a Teaching and Learning Strategies section of their curriculum document.

The humanistic philosophical framework is evident in the all the comparative criteria, however it is particularly obvious in Criterion 3.a) desirable qualities of the graduate, where three of the four curricula discuss goals rather than objectives. Kwantlen University College is the only curriculum document stating an objectives format for graduate qualities, but this will undoubtedly change as the school allies itself with the Collaborative Nursing Program in 1996.

To promote intraprofessional communication and role understanding in a collaborative curriculum, requires a commonly accepted perception of the curriculum by faculty, a climate that features dialogue rather than polemics and a curriculum that sustains an egalitarian position. Curriculum viewed as interactions, as opposed to an authoritarian position where the manner in which the interactions occur, and what they lead to, is the curriculum purpose.



Such an egalitarian climate, where interaction and dialogue can take place, is compatible with the theories and principles of humanistic education and it is this conceptual framework that supports collaborative, basic encounter group idea-sharing to erase the stereotypes clinging to both the nursing and midwifery professions and promote inter-professional understanding.

## 2. Common Theoretical Content

There is a large area of theoretical content common to the selected nursing and midwifery education programs and this can be divided into two knowledge-base sections. The first knowledge-base section consists of the lab/clinical/technical skills; the "training" aspect of nursing and midwifery, and knowledge transfer responds well to the traditional curriculum. The second knowledge-base section is usually taught by classroom/module/clarification courses, the educational material that is compatible with humanistic qualitative principles.

The common content relating to the "training" aspect of nursing and midwifery, includes the care of the person/child-bearing family during their experiences associated with reproduction. Of the four selected programs, two deal with students who are already registered nurses(see Criterion 1). This occurs in Options A and C, University of Victoria, Collaborative Nursing Program, and with Epsom and Kingston College of Nursing and Midwifery/ NESCOT, and as a result most of the basic care skills are unnecessary within their

curricula. However these skills are incorporated within the curricula of the remaining programs from Ontario and Kwantlen University College.

Another common area of theory content involves "medical conditions" common to both programs, such as diabetes, for example. The two selected midwifery programs consider the condition as it affects the reproductive process. However, one of the selected midwifery programs (Epsom and Kingston College of Nursing and Midwifery/NESCOT) educates registered nurses, (See Criterion 1) who already have theoretical knowledge and clinical experience of diabetes that is not confined solely to its impact on reproduction.

Secondly, although the condition may not affect the pregnant woman physically, it may affect a close family member, and that in turn will certainly affect her experiences with pregnancy and childbirth, emotionally, financially and socially. A holistic approach is necessary for the professional midwife, to be alert and knowledgeable to all facets of health and the presenting experiences of the childbearing family.

The theoretical content listed below is divided into two sections. The first list of theoretical content responds well to the traditional training curriculum and the second list of theoretical content to the qualitative/phenomenological curriculum. I acknowledge that some of the listed topics do not need teaching to students who are registered nurses. I also acknowledge that certain topics may respond favorably to

knowledge transferal utilizing both types of educational philosophical beliefs, but have classified them into the lists as they are currently taught.

The common theoretical content (training content) includes:

- general and obstetric physical assessment,
- history taking and interviewing,
- basic physical care including the assessment/recording of vital signs and fetal heart rate monitoring,
- laboratory tests, diagnostic screening,
- adult and neonatal emergency procedures, and CPR,
- basic pharmacology, medication calculations and dosages, injection techniques, IV maintenance,
- asepsis and aseptic techniques,
- catheterization,
- basic ante/intra/post partum care,
- basic newborn/infant care including infant feeding.

The common theoretical content (educational learning) are:

- basic theory in sociology, psychology, human biology and anatomy and physiology;
- "medical conditions" in relation to the health experiences of the child bearing family;
- nursing and midwifery studies integrated with women's studies, professional practice and state regulation;
- the health care system/services and the professional role within that service;
- ethics and law, often integrated with other content;
- communication, teaching and learning components;
- professional research, emphasized in all the selected curricula;
- a care process based on a nursing process.

## **A Framework for a Collaborative Fundamental Curriculum for Nursing and Midwifery Education**

There are certain factors to consider when suggesting a collaborative fundamental curriculum. Firstly, I acknowledge the fact that this is the opinion of only one person, rather than a group process. Secondly the financial implications, education setting/resources, professional practice issues, and media stereotyping must be considered and will be further discussed in Chapter 5.

As well as identifying the curriculum content common to nursing and midwifery education programs, the descriptive comparison in Chapter 3 also identified the fact that the content is common to/and has an impact at the post-graduate (registered nurses) as well as the undergraduate (nursing and midwifery students) education levels. Two of the selected curricula educate RN postgraduate students i.e., in Options A and C of the Collaborative Nursing Program—University of Victoria, the student has already gained a Diploma in nursing and in the midwifery program, Epsom & Kingston College of Nursing and Midwifery/NESCOT, the student midwives are also RNs. The remaining two selected curricula, Kwantlen University College and the Ontario Universities Consortium educate undergraduate students.

Therefore the first part of this section will examine a framework for a collaborative fundamental curriculum for the undergraduate level, followed by a framework for the post-graduate level i.e students who are registered nurses.

Currently in British Columbia there are two education routes for students who wish to become registered nurses.

1. Diploma in Nursing. This is a two year program and is the minimum nursing education requirement.
2. Baccalaureate in Nursing. This is a four year university program, completed in one of two ways, either:
  - a) by completing a four year approved university nursing program, or
  - b) by completing the final two years of an approved university nursing program, by returning diploma level registered nurses.

Nurses are encouraged to continue their education beyond the Diploma level, and the RNABC in a position statement, suggest that the basic education requirement for nurses entering the profession in the future should be at a baccalaureate degree level (RNABC,1994, Education Requirements for Future Nurses).

It is suggested that the basic education requirement for midwifery in British Columbia will also be at a baccalaureate level. The Ontario Universities Consortium program, leading to a Bachelor of Health Sciences (B.H.Sc.) in Midwifery, is a three year full-time program, although students do have a part-time alternate curriculum, with a suggested five year course sequence outlined in the Ontario curriculum document.

The RNABC, responsible through the Nurses (Registered) Act for standards for education of nurses in British Columbia, have identified nursing competencies and skills to describe the expectations for new graduates entering the nursing profession (Nursing Competencies and Skills Required

of the New Graduate, RNABC, 1990). Combined with "Standards for Nursing Practice in British Columbia" (RNABC, 1992), the two documents are used by education institutions, to evaluate their nursing programs.

The nursing competencies, skills and the maternal-child minimum standard nursing skills required of the graduate and defined in RNABC document, Nursing Competencies and Skills Required of the New Graduate, cover most of the common theoretical content identified by the descriptive comparison and already introduced (see p.114). Specifically, the maternal-child skills are listed below.

Maternal-child nursing(mother)

- assisting with breast feeding
- assisting with expression of milk
- assisting with breast care
- assisting with exercise(e.g.,post-partum)
- caring for episiotomy
- evaluating lochia
- evaluating fetal heart sounds
- evaluating fundus
- massaging fundus
- timing uterine contractions

Maternal-child nursing(neonate)

- bathing
- bottle feeding a neonate
- caring for circumcision
- caring for newborn immediately after birth
- caring for umbilicus
- caring for a neonate receiving phototherapy
- setting up and maintaining an incubator  
(RNABC,1990,p.12)

Of the identified common theoretical content (see p.114) all of the "training content" and a large percentage of the "educational learning" content are necessary knowledge base areas and must be presented in Year 1 and 2, in both nursing

and midwifery education programs. This content could be presented in a collaborative fundamental curriculum.

To achieve this will require dialogue and innovation between the administrators and educators of the nursing and midwifery professions. This is another area where the basic encounter groups (Rogers,1969) might be utilized to promote idea sharing at an administrative level, prior to considering strategies for a collaborative effort, to start the process of idea sharing and inter-professional understanding at an undergraduate level.

There are many areas where the use of basic encounter group sharing could promote student dialogue and interaction. For example, ethical issues could involve discussions on topics such as; sexually transmitted diseases and adolescent sex education; the use of technology, especially in such areas as induction of labour, caesarian section and medical/ surgical interventions; and technological interventions with grossly premature infants.

Role understanding can be enhanced when nursing and midwifery studies are integrated with women's studies, as well as group discussions concerning the health system/ services, and examining the respective roles of nursing and midwifery, as members of the health care team within that service.

The exposure of students to faculty and speakers from other health care disciplines can also be a positive and educationally liberating experience for students, broadening

knowledge and perceptions. Sharing faculty already occurs in the majority of provincial nursing programs, where basic human anatomy, sociology, and psychology are taught by other departments, within the same educational institution. Another example of faculty sharing occurs at the British Columbia Institute of Technology (BCIT), where bio-medical and radiology technicians are taught certain components of their curricula by nursing faculty.

Benner (1984) and Bevis (1989) support alliance with clinical specialists, valuing individual clinical expertise for nursing education, and this position is supported in both the selected midwifery curricula used in the descriptive comparison. Bevis (1989) suggests tripartite alliances where teachers, expert clinical nurses and students, are co-learners together.

This position is reflected in the current British Columbia nursing programs, and is clearly demonstrated in the BCIT post-diploma nursing programs. These alliances in nursing programs take the form of preceptorship mentoring, clinical teaching, and guest speakers for core, theoretical curriculum components. Most of the major hospitals in Vancouver and the Lower Mainland employ Nurse Clinicians/Educators/Specialists, with expertise in their chosen speciality areas. This expertise covers the common theoretical content areas, identified by the descriptive comparison. Not only does such an alliance promote



interprofessional interaction, but can also be cost effective.

Another consideration when discussing collaborative education is the cost factor. To implement and establish a midwifery program requires considerable funding, an educational setting with adequate resources and accessibility to clinical placements for students, and it is my opinion that the ideal place to initiate a common fundamental curriculum and to eventually locate a midwifery program would be at BCIT. The institution already has a large proportion of the necessary funding required to present the post diploma obstetrical nursing program, the educational setting/ resources and a faculty already experienced with a program that has gained credibility within health care agencies by proving its excellence with quality education.

A few options to consider are:

1. that the present post-diploma obstetrical nursing program at the British Columbia Institute of Technology (BCIT) continue in its present format, leading to a degree in health science, or
2. that the present program be revised to become a midwifery program, or
3. that the present program become a two level, certificate and degree program in perinatal nursing, or
4. that (Theory 1 and 2), the low to moderate risk components of the post-diploma obstetrical nursing speciality program

become incorporated into the BCIT Diploma Nursing Program as elective courses.

In this option, Preceptorship 1 and 2 can also become integrated into the final Diploma Nursing Program preceptorship course component, by those students with an interest in furthering post-diploma career options in either midwifery, or option 3 for a degree in perinatal nursing.

Given this scenario, and depending on demand, the present post-diploma obstetrical nursing speciality program could eventually be developed into a midwifery program.

It is my opinion that options 3 and 4 listed above are the ideal climates where a collaborative fundamental curriculum is possible to implement at the undergraduate and post-graduate levels. This framework can be used to present the low to moderate-risk components one of two ways:

- to diploma nursing students as elective courses, building on the basic obstetrical theoretical knowledge already incorporated into the Diploma Nursing program, and
- simultaneously being offered either by distance education, or in its compressed time frame format to registered nurses, for a certificate in perinatal nursing.

Both groups of students will then have the choice to continue on to the baccalaureate degree level in perinatal nursing.

If a midwifery program becomes reality at BCIT, it could be offered to students as a alternate route alongside a degree in perinatal nursing, with the parallel programs

sharing facilities, and common fundamental curriculum interaction.

I also feel that Option 3 must be maintained for post-graduate nurses, many of whom have years of experience working in provincial obstetrical units and public health facilities. Many of these nurses, while wishing to extend and formalize their knowledge and gain a degree specializing in their chosen area, have no wish to pursue a career in midwifery, and this option should remain open to them.

This section has outlined a framework for a collaborative fundamental curriculum and discussing the options at the undergraduate (Diploma level) and post-graduate (RN) level. As already stated these are the opinions of one person only, and this is a situation that needs to be researched in greater depth by administrators, educators and professional associations to examine the logistics of such a collaborative venture.

## Chapter Five

### Considerations and Implications of a Collaborative Fundamental Curriculum Framework

The British Columbian health care service has undergone major changes in recent years, and is still in a state of rapid change. Many factors, financial, political, and social, have contributed to this change. There have been rapid advances in technology and medical scientific knowledge, with the accompanying financial impact on the health care service.

Responding to these rapid changes the educational institutions in British Columbia are exploring and initiating innovative ways to increase accessibility to education programs, with education programs that remain sensitive to societal changes and an increasingly well-informed population.

Nursing educators and professional associations are seeking education programs that reflect a move from the technological/behavioristic models; for a qualitative/educative/caring paradigm to be employed in the education programs of health professions who contend on a daily basis with societal and workplace demands, rapid technological changes and the accompanying ethical dilemmas (Segaric, 1993). Programs that encourage critical thinking, self initiated learning, student participation in planning and evaluation, the instructor as facilitator and group methods.

Programs that graduate professionals who are independent, inquiring, critical, creative, caring and reflective.

Although the educative-caring paradigm as described by Bevis (1989) is intended for nursing curriculum development there is much to commend it to midwifery education. Curriculum development is anchored firmly within the contemporary and future trends/needs of society, health care and the nursing profession.

With so much common content between the selected education programs of nursing and midwifery, identified in Chapter 4 (p.114), and a midwifery educational philosophy that is compatible with the new educative-caring direction being sought by nursing, a collaborative fundamental curriculum can go a long way to promote interprofessional understanding; to maintain "a vision of what is and what can be" (Bevis, 1989, p.114).

This concluding chapter will examine some important considerations that also have an impact upon the proposed framework for a collaborative fundamental curriculum. These involve the financial considerations, education setting/resources, professional practice issues, and finally, the media stereotyping of nurses and midwives.

#### **Financial Considerations.**

To implement new programs takes a considerable amount of financial planning and access to readily available financial resources. Educational institutions are already facing

financial restraint, and as a result many have formed collaboratives with other institutions, while yet others are exploring the logistics of collaborative programs as one means of reducing costs, and in an effort to avoid duplication of courses.

Given the extensive amount of common theoretical content between the nursing and midwifery education programs, such a collaborative venture would seem logical. However I reiterate, that this is not to suggest that midwifery becomes absorbed within a nursing program. Both programs have extensive bodies of knowledge, specific to their respective profession. What I am suggesting is that they recognize the common theoretical content, and collaborate at a common fundamental level.

The major focus of this thesis is to suggest that by collaboration, the two professions could start the process of dispelling anomalous stereotypes, however in this case collaboration could serve yet another purpose. Forming an alliance with a nursing program would not only help to promote interaction and interprofessional understanding, but would also be cost effective and avoid course duplication.

The collaborative focus was very apparent in three out of the four curricula in the descriptive comparison, and Kwantlen University College proposes to enter the Collaborative Nursing Program in 1996.

#### **Educational Setting/Resources**

As already stated, BCIT would seem to be the logical

place to start a common fundamental curriculum, and this would cover undergraduate and postgraduate education levels, if Options 3 and 4 were exercised. This institution already has the administrative facilities, the educational resources including library, computer, and learning resource center facilities, as well as experienced faculty in place, at the diploma and the post-diploma nursing programs levels.

However, this is not to suggest limiting the concept of a collaborative fundamental curriculum to one college. With the goal of interprofessional understanding being the major consideration, such a undergraduate program could be located at any of the colleges, where a nursing program is offered.

The concept of a collaborative fundamental curriculum could be extended further as a means of making such programs more accessible to students in inaccessible geographical locations, to include collaborative alliances between a few educational institutions, as in the case of the Ontario Universities Consortium.

Portable course credits should also be a feature of the collaborative curriculum framework, again to avoid course repetition, added expense and the accompanying student frustration. It also allows more choices for the student who may want to transfer from one program to the other, within the collaborative.

Clinical placements must also be given consideration when discussing educational setting. This is a major problem

in British Columbia's obstetrical units and community settings already over-strained with students.

There is also a degree of resistance to midwives amongst health care professions, other than nursing, and this is another area where collaborative efforts and interaction is needed to promote interprofessional understanding and help to eradicate long held misconceptions. Physician resistance is very real, and has already led, to territorial disputes, over the years (Northouse and Northouse, 1992) and is another area that needs a great deal of communication and negotiation to improve interprofessional understanding.

Barclay, Andre and Glover (1989) assert that while many of the experts discuss sexism, professional elitism and medical dominance over "less prestigious female health care workers", another issue that is rarely discussed is the economic consideration. Forster (in Barclay et al, 1989) states that,

many doctors feared that the fully qualified midwife would not only take over obstetrical practice, but also invade the lucrative field of diseases of women (Forster in Barclay, Andre & Glover, 1989, p.128).

This quote was describing a debate on midwifery education a century ago and is an issue, that Barclay et.al. maintain, that is still relevant today.

### Professional Practice Issues

While the Registered Nurses Association of British Columbia, in a position statement on midwifery, supports the recognition of midwifery as a regulated health profession



(RNABC,1993), they believe that nurses who are also qualified midwives should be able to choose to have their midwifery practice regulated by the RNABC.

The RNABC also supports regulatory options for nurse-midwives. Nurse-midwives who choose to be regulated through a College of Midwives rather than the RNABC, for the purpose of practising midwifery, should have the option of also maintaining registration with the RNABC, so they may continue to practice nursing (RNABC,1993).

This covers the regulatory position of the nurse-midwife, but does not address many issues raised by the obstetrical nurses. These nurses are availing themselves, in greater numbers, of the post diploma obstetrical speciality/degree program at BCIT, but remain unsure of their position in the future health care system. As members of the British Columbia Nurses Union, will their position be protected or will they be usurped by a midwifery service? Many of these nurses have no wish to become midwives, but never the less question the logistics of undertaking further education if they are limited in employment opportunities at the end of their studies.

This is an administrative/regulatory/union issue that requires extensive collaborative efforts by the involved regulatory bodies in order to resolve it. I feel strongly that nurses and midwives can be educated together within a collaborative fundamental curriculum framework and graduate

with a better understanding of one another, enhancing a collegial working atmosphere.

This is one of the areas identified by Northouse and Northouse (1992), where role overlap leads to an increase in territorial disputes, and is counter productive to inter-professional understanding. Once again, reducing and eventually eliminating territorial disputes can be improved by interaction, and increased role understanding in the educative setting.

#### **Media Stereotyping.**

In contemporary society, one of the most powerful institutions is the mass media, television, the press and to a lesser degree, the movie industry. Television in particular, can be insidious and a good percentage of the population make value judgements from the images projected in their living rooms, on a daily basis. When these images concern nursing and midwifery they are generally negative. There is rarely an instance when girls and women see members of either of these two highly educated professions, portrayed by the media, as role models.

I surveyed a few adult and teenage women, to gauge their reaction to this negative image portrayal, and the responses were as I had expected. The nurse is portrayed as a "sex object" in her youth, and as a "bully" and a "battle-ax" in her middle years. Among some of the stereotypes cited were, the nurse in "Roger Rabbit", "Doogie Howser M.D." and "E.R."

where nurses are portrayed as subservient to physicians and finally, the nurse in "One Flew Over the Cuckoo's Nest".

The group of women could not cite one instance when they had admired the nurse/s character, and the teenage responses went further, to clearly state that they had no intention of being treated in such a manner when they became members in the workplace.

Nursing must continue to respond, to change this image and allow the public to see that this negative stereotyping is not a true reflection of professional nursing practice.

Midwifery, as it is currently practiced in British Columbia, is perceived as a sub-culture by a large percentage of obstetrical nurses and nurse-midwives. British Columbia has witnessed some fairly sensational press reporting in recent years regarding controversial cases involving untrained midwives. This situation succeeds in further reinforcing the negative image of midwives, held by many nurses, who have no wish to be grouped with what they consider to be an untrained fringe element.

Again this is a situation that could be improved by education. By bringing nurses and midwives together in a collaborative fundamental curriculum will allow the two professions to share ideas, values and perspectives in an attempt to improve interprofessional understanding.

In conclusion, this thesis has examined the question: Is there a common curriculum base to the education programs of nursing and midwifery sufficient to develop a framework for a

collaborative fundamental curriculum? The historical and social dimensions to the stereotyping of nursing and midwifery roles have been discussed, four selected curricula, two from nursing programs and two from midwifery programs, have been examined to determine the philosophical and theoretical content common to both professions, as well as suggesting a framework for a collaborative fundamental curriculum and some implications to consider for future collaboration.

Finally, the issue of nurse-midwifery/midwifery will no doubt continue to generate controversy for many years to come, but it is with concern that I hear Ontario nurses-midwives having to suppress their nursing qualifications for fear of upsetting midwives. In this author's opinion one only has to look to history for a parallel to this dilemma. A few centuries ago physicians and barber-surgeons (the fore runner of the surgeon) had a similar power struggle. They had the good sense to realize that to provide the care and to maintain a united, organized profession, they must recognize their similarities and stop dwelling on their differences. Nursing and midwifery would do well to learn from this lesson.

Level/ classification	Titles used	Education/training required	Functions performed and independent judgement required
<i>Professional</i> Midwife	Midwife Feldsher-midwife	Secondary education plus minimum of 3 years' midwifery education.	Provides care and health education during pregnancy, labour and post- natal period. Manages apparently normal labour without supervision. Cares for newborn infant.
Nurse-midwife	Nurse-midwife	Secondary education, recognised nursing education plus 6-12 months' midwifery education; post-basic training in maternal and child health, advanced midwifery, community health nursing neonatal nursing.	Identifies and refers abnormal con- ditions and clients at risk. Carries out gynaecological and family planning activities. The above activities can be exercised in the areas of teaching, administration (including supervision), and research.
<i>Intermediate</i> Auxiliary or assistant midwife	Auxiliary midwife Assistant midwife Practical midwife Rural midwife Enrolled midwife	6-8 years' general education plus 1-2 years' midwifery training.	Provides care and health education and manages apparently normal labour, usually under direct professional supervision. May supervise lower- level aides. May be trained to work independently where manpower is in short supply eg, in rural areas.
Auxiliary or assistant nurse-midwife	Auxiliary nurse-midwife Assistant nurse-midwife	6-8 years' general education and 1-2 years' training as an auxiliary nurse, plus 1-2 years' midwifery training or 2-3 years' integrated nursing and midwifery training at auxiliary level.	May qualify to train for professional- level positions through acquiring the requisite level of general education to enter professional education programmes, special curricula, etc, befitting requirements specified by the country.
<i>Non-professional</i> Aide	Maternal and child health aide Midwifery aide  Trained traditional birth attendant	0-6 years' general education plus on-the-job training in midwifery.  On-the-job training in midwifery.	Carries out clearly specified tasks in the care of maternity patients and newborn infants, under direct supervision.
Traditional birth attendant	Numerous titles, varying from country to country	Training acquired through working with another traditional birth attendant in apprenticeship fashion.	Normally operates outside organised health system; assists mothers in deliveries; performs bulk of deliveries in rural areas of many countries, owing to inaccessibility of formally training health man- power and community acceptance of traditional practitioners.

The Aims of the Course

The aim of the course is to produce a midwife who:

1. is a competent, autonomous professional practitioner of midwifery;
2. is able to:
  - (a) provide sound family planning information and advice;
  - (b) diagnose and monitor normal pregnancies;
  - (c) prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
  - (d) provide a programme of education for childbirth and parenting including advice on hygiene and nutrition;
  - (e) care for and assist the mother during labour and monitor the condition of the fetus by appropriate clinical and technical means;
  - (f) conduct spontaneous deliveries including an episiotomy and in urgent cases a breech delivery;
  - (g) recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus;
  - (h) examine and care for the new-born infant; to take all initiatives which are necessary including immediate resuscitation;
  - (i) care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant;
  - (j) maintain all necessary records;  
(A Midwife's Code of Practice 1991)
3. demonstrate the educational outcomes cited in the Handbook of Midwives Rules, Rule 33 (March 1991);
  - "(c) enable the student midwife to accept responsibility for her personal professional development and to apply her knowledge and skill in meeting the need of individuals and of groups throughout the antenatal, intranatal and postnatal periods and shall include enabling the student to achieve the following outcomes:
    - (1) the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health;

- (ii) the recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action;
  - (iii) the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family;
  - (iv) the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required;
  - (v) the ability to interpret and undertake care prescribed by a registered medical practitioner;
  - (vi) the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines;
  - (vii) the use of relevant literature and research to inform the practice of midwifery;
  - (viii) the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team;
  - (ix) an understanding of the requirements of legislation relevant to the practice of midwifery;
  - (x) an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice;
  - (xi) the assignment of the midwife of appropriate duties to others and the supervision and monitoring of such assigned duties." (Midwives Rules 1991)
4. demonstrate a caring and sensitive attitude towards women and their families within a multicultural society;
  5. show awareness of the political, economic, social and technological environment in which s/he practises;
  6. continue to develop knowledge and skills through the education programme and during their career as a professional midwife.

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