We have long lamented the tendency across the Western world whereby midwifery education programmes are made to ensure that students gain experience which is counted in primarily in quantitative terms. In the European Union, for instance, student midwives must *advise* pregnant women and undertake 100 pre-natal examinations, *supervise* the care of at least 40 pregnant women and *conduct* at least 40 deliveries. Students are expected to do a number of other things before they can qualify as well, including being *initiated* into suturing and *caring for pathological cases*.

We have a number of concerns about the use of these kinds of standards, not least of which is the use of the patriarchal terms that we have italicised in the previous paragraph. The standards do not match the lived reality of becoming a midwife, whereby some students may feel ready to practice after attending 30 births, while some may not feel fully prepared after 50. In common with many of our colleagues, we are uneasy about the fact that the standards are based on the assumption that experience and competency can best be measured numerically. While our experience as midwifery educators means that we understand how hard educators and practitioners work to include other ways of assessing competence, some of which are qualitative and experiential in nature, the reality is that these numerical standards have to be adhered to.

Get Your Gloves On – Room 13 is Fully!

Given that we live in a world where bureaucracy, standards and norms are considered by many to be the fabric that holds the universe together, this situation might be more tolerable if not for the impact that it has upon students, women, midwives and midwifery educators. In almost every final year midwifery group, lunchtime conversations begin with the question, "how many are you up to now?" and students congratulate and sympathise with each other about their progress towards the magic number of 40 births.

This phrase is also often used by mentors and personal tutors who will seek to take action and help those students who, usually through no fault of their own, are lagging behind their classmates in the numbers race. The upshot often includes putting student midwives on night shifts, where they are perceived to have a greater chance of normal births (an issue on which another whole article could be written), or enlisting the help of kindly labour ward co-ordinators who will send the less numerically fortunate students running into delivery rooms at the last minute in order to 'get their gloves on and their numbers up'.

The Numbers Race

There is no sense in which we are criticising the actions of any of the people in this situation. These problems result from the fact that we all have to conform to bureaucratic, numerical standards which, as inert rules on paper, do not understand the reality of what it is to be a student midwife who is studying at university and working in a busy hospital while trying to have a personal and family life in her spare time. The rules do not care that they may cause women to have fragmented care, as students rush in late on in their labour to catch their babies and placentas, and the rules do not care if they add, even slightly, to the viewing of women and babies as numbers rather than as embodied people who are undergoing one of the most potentially transformative experiences on Earth.

We do care, not least because one of us (Lorna) has moved from the UK to New Zealand (NZ) and, as a midwifery educator, has seen at first hand how different things can be when numbers do not take a place of supreme importance. The following scenarios (based on real students whose names have been changed) illustrate the difference between the UK situation and the current situation in NZ.

- **Chloe** is a third year undergraduate midwifery student in the UK. It is only four weeks until she qualifies and she has only carried out twenty five normal deliveries. She is aware that there is a clause that accommodates for situations where clinical areas are under pressure and the births are not available, yet she still needs to attend a minimum of 5 more 'normal' births and is feeling under intense pressure, not least because a recent audit showed her unit's caesarean section rate to be 32%. She had no problems in getting her 100 antenatal examinations signed off by the end of the first year of her training and she and her fellow students joke about how quickly they all managed to tally up 40 women who were considered to be 'at risk'.

- **Mouena** is a third year midwifery student in New Zealand and, like Chloe, is also on a three year midwifery degree programme. The NZ requirements in terms of practice experience are not as prescriptive. Mouena does not have any specific numbers to achieve relating to ante-natal and post-natal examinations, but she does have to be able to demonstrate that she has participated in the continuity of care of at least 30 women and has facilitated a minimum

of thirty births during her undergraduate preparation. A follow through experience is defined as follows; Mouena will have met each woman during the ante-natal period whilst working alongside a midwife in the apprenticeship model. She will have attended her birth, which is counted even if it is a caesarean section, and will have undertaken post-natal visits for between 4-6 weeks after the birth. Each of these continuity episodes constitutes a follow through experience. Mouena will have almost certainly have carried out 100 antenatal and postnatal assessments during these experiences, but the emphasis is on quality and continuity rather than quantifying and counting each individual activity which, as above, often leads to fragmentation. Students in NZ do spend some time working in a hospital, so if they do not manage to achieve the requirement of thirty births with the women that they are following through, then they will normally gain enough additional experience during their hospital based practice placements.

Is Imperialism too strong a word?

The New Zealand educational model is viewed by many as a valiant attempt to embrace an emphasis on quality and continuity and truly place women at the centre of care. If we had been writing this article six months ago we may have been holding it up as a standard of best international practice and calling for other countries to follow suit. Unfortunately, a series of events have precipitated a consultation, the outcomes of which have led to a change in the standards for approval and accreditation within NZ midwifery education. The most significant change in relation to this article is that NZ has made the decision to adopt the EU Directive as the standard for midwifery practice requirements.

There are a number of reasons for this: more than we can begin to discuss within a short article. However, one of the key reasons is the fact that overseas experience (OE) is a significant part of New Zealand culture and many midwifery students aspire to practice abroad, with a particular emphasis on the UK. Until recently, NZ qualified midwives had no problem in registering with the NMC. However, in the past couple of years, NZ midwives have found themselves turned away because the quantitative element of their education (which includes clinical and theoretical hours as well as practice numbers) is not deemed to fit with the EU specifications. In brief, the situation has led to feedback from NZ students requesting that their degree programmes should meet the UK/EU requirements for midwifery registration, which of course includes the package of numerical requirements (MCNZ 2007a, MCNZ 2007b).

It seems a great pity that NZ which, in a well established pioneering spirit, set out to demonstrate to the rest of the world that women and the quality of their experience mattered more than mere numbers, have had to undertake a U-turn and subscribe to the bureaucratic constraints of the EU, some 12,000 miles away! The organisations and individuals who participated in the consultation process that ultimately led to this decision were almost unanimous in their opposition to the potential adoption of a number-based method of assessment of competency. In spite of this reticence and the international acclaim that followed the renaissance of midwifery in New Zealand, it would appear that this small and independently spirited country cannot easily stand against the mighty and faceless patriarchal bureaucracy of the European Union.

Rather ironically, it would seem that numbers are winning on more levels than one. The stark reality is that, if communities such as the EU were a bit less expansive in terms of population and power, smaller countries like NZ might stand more of a chance of bringing challenge and change to the table. Instead, and in spite of the excellence of the more qualitative, woman-centred and student-friendly NZ model, it is the lowest common denominator ~ in the shape of quantification of competency ~ that is fast becoming the global framework. We can only hope that, once this change allows NZ-qualified midwives to work in EU countries again, they may at least be able to share some of the advantages of their model with the European midwives who do not have the chance to practice in the same way.

References

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