16th July 2009
Sonya Beutel

Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee

By E-mail: community.affairs.sen@aph.gov.au

Dear Senator Moore

Re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

As a midwife of 11 years, who has worked both in a hospital setting and more recently in the community for the past 6 years, I have cared for many women, with many stories to tell. Women are experiencing post traumatic stress disorder following the births of their babies and are carrying this disability with them in their every day lives. For those who find the strength to face having another baby, some come seeking the services of a midwife in private practice to begin to heal and rebuild their lives, and others detach themselves and book an elective caesarean. The long term effect this has on bonding and relationships within the home is huge.

Regardless of the level of risk women WILL choose to birth at home. Previous caesarean, more than 5 babies, cardiac conditions, breech, pre-term, previous stillbirth – each of them just as determined as the next to *not* go to hospital. Each of them feeling that being at home with a midwife who knows them, knows their story, knows their fears is substantially safer than being in an institution where they perceive themselves as a number amongst strangers who dictate to them who can be with them when they birth their baby, whether they can use hot packs for relief or not, prohibiting them from nutrition during a time when their body requires refueling frequently, all because they are having a baby and might need surgery.

Being placed in a position where the women are well informed, mentally competent and have the support of their partners, they make choices that mean they don't fit in the "box" of standard low risk clients but decline going to the hospital to give birth. Some decline even having hospital visits which can be quite challenging especially if they fall outside out guidelines.

Over the past 6 years I have developed a collaborative midwifery practice which has enabled me to liaise with the Obstetricians in the hospitals and the family GP's in my district. This has been to ensure each woman has access to additional information and medical practitioners for

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further counseling regarding the choices she makes around her baby's birth, and she is well informed. In my experience, most women choosing care with a midwife in private practice engage the services in the first 8 weeks of pregnancy if not pre-conception to ensure a healthy conception through discussion of nutritional and health concerns. The booking process involves;

- A full physical, emotional and psychosocial screen of mother and when possible father. Medical, surgical, obstetric history, sexual health, drug and alcohol and social risk factors screening.
- Women have a booking visit which can take up to three hours where all aspects of health are checked including blood pressure and urine, gestation calculated according to clinical indicators and menstrual / conception history, and any risk factors are discussed, mental health and associated issues are addressed and referrals made when required.
- Arranging for routine best practice pathological screening and ultrasound examinations.
- Booking each woman into her nearest birthing facility in the event transfer is requested or necessary on clinical grounds. Transfer criterion is generally gauged according to the Australian College of Midwives "National Midwifery Guidelines for Consultation and Referral" (2008).
- Engaging and consulting with a staff Obstetrician as required.
- Engaging by correspondence with the woman's family GP to keep them informed of her pregnancy and birth care plans and progress with results of screening.
- Forwarding a copy of the woman's medical, obstetric and psychosocial history to both medical practitioners
- Extensive education related to healthy choices for pregnancy. Nutrition, exercise, social risk factors and emotional health.
- Partners, children and other support people are encouraged to attend education sessions and antenatal visits. Well women pregnancy visiting schedules are in accordance with the NICE or QLD Health guidelines as a minimum, however some women require more frequent visits if emotional factors are present as they work through previous emotional birth traumas.
- A second midwife is engaged in the third trimester (at the latest) to ensure they are fully informed of the clinical and emotional aspects of each client ensuring safe practice. The woman primarily has her consultations with me, but has the availability of another known care provider if I am unavailable at any stage throughout the episode of care.
- When labour begins the woman or her partner contact me and I attend her at home. After clinical assessment of mother and unborn baby if both are assessed well we remain at home. If however there are any concerns we transfer to the back-up facility. The second midwife is requested to attend at home once labour is established or when

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the birth is imminent. If the labour is long the second midwife provides back-up care at home to enable the primary midwife time to rest. Once the baby and placenta are born I provide care for the mother and baby, observing physical health of both, may suture the mother if required, help to initiate breastfeeding, early bonding and parenting. There are no strict timelines placed on women for the birth of either the baby or the placenta, this is assessed on a client by client basis. Likewise, after the birth, I/we stay with the family for as long as is needed. I then return within 12-24 hours (sooner if required) to reassess mother and baby and provide ongoing support and education.

- Birth documentation, birth notification and registration, and data collection is completed and submitted.
- I visit the family at least daily for three days, collect any neonatal screening that is required and continue to provide support for breastfeeding and caring for her baby; again referring mother or baby if any concerns develop that is beyond the scope of the midwife; weighing baby; checking milestones, organising healthy hearing screening; ongoing education. During this time I spend a great deal of this time assisting the mother to gain confidence and monitor her emotional wellbeing - assisting her in dealing with any concerns which may arise. The amount of contact is usually determined by both the midwife and mother. Usually at some point the midwife will sit and discuss the birth with the mother and family (often many times), forming an informal type of "debrief" which helps women and their partners to understand the birth better. If there are any concerns, the midwife can see the woman for longer, but will also refer women on to child health nurses or to GP's to continue health and development checks for the baby.
- Care of the woman and her baby spans the entire pregnancy until 6 weeks after the birth.
- At 6 weeks I engage the family in a formal debrief of their pregnancy, birth and parenting experience up to this point, answer their questions, clarify and situations that arose, seek feedback from them on the care they received and recommendations for improvement. All parties present at the birth are invited. This is however not possible if the birth occurred as a hospital transfer but I encourage the families to offer the hospital / staff feedback in a written format if they desire.

When a woman is selecting a Midwife to be her primary maternity carer, the woman has a contract with that midwife and an expectation that the midwife will support her in her choices, advocate for her, provide her with education, but most of all respect her as the owner and decision maker over her body and her baby. In situations where the mother is choosing a path that is outside the recommendations of the ACMI consultation and referral guidelines, the

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woman and midwife follow the consultation and referral pathway. This pathway includes the woman's right of informed choice, and the right of refusal. In my practice when this situation arises I discuss my concerns with the woman, and consult and notify the Obstetrician. If the woman consents we consult with an Obstetrician together to ensure the woman has been counselled by two separate professionals and informed choice is facilitated.

At the completion of care at 6 weeks, the client receives a full copy of their records from my care, as I find full disclosure is a key element to trust and satisfaction. Through education and *true* informed consent the women and their partners want to take responsibility for the choices they make despite the outcomes because they have a sense of ownership and control over their process rather than having it "done to them" which is an extremely common reflection reported to me. Partners are excited to be engaged in the birthing process as their baby is welcomed into the world rather than feeling they are there out of obligation or expectation. Partners also report to me repeatedly the negative experiences they have had with hospital birthing. The lack of engagement, lack of education, and simply a lack of acknowledgment placed upon them as an important part of the experience of becoming a father.

"When a women gives birth it is not about the birth of a baby, but the birth of a family"

It saddens me greatly that as of July 2010 I may not be able to attend families in their home for the birth of their babies. After working in the hospital for 5 years before moving into a community practice it has been an amazing and transformational experience and one I will carry with me always close to my heart. Women who have been told their body has failed them, they were too short, pelvis too small, baby too big, too old, just not good at having babies yet witnessing them embrace their labour and be changed women and men after birthing their baby from their bodies - the photos speak a thousand words.

At the end of the day what we all want is healthy mothers and babies, but a head count is not a measure of health. The mental health that is being affected through birth is growing. It affects relationships, bonding between parents and babies, the number of babies a family will have. Since the announcement of the proposed illegalisation of homebirth I have had so many families contacting me while they are frantically trying to conceive before the end of August this year, and those who are proposing to birth unattended at home if they are after 1st July 2010. There is also a large element that will simply have no more babies just because going back to hospital to give birth is not an option but they wouldn't birth alone.

What concerns me the most it the number of women who will birth at home unattended. There have been births I have attended in the home where babies or mothers would not be alive if I was not there. Situations that required attention that was reversible but would have been catastrophic if those births were unattended.

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It would be very naive decision to ban homebirth as it WILL continue to occur but the women and the *unqualified* people attending them will be driven underground and the health of mothers and babies WILL be severely compromised. Please reconsider and look for other alternatives to the legislative changes as other countries have done and keep our mothers and babies safe by allowing those of us who are qualified and highly skilled to continue to do what we are trained to do. Remember safe birth is not just about a head count, it is about the emotional health as well. Homebirth can be a healthy option for families, and should remain available and supported.

Yours sincerely

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