

HOME BIRTH  
AUSTRALIA



20 July 2009  
Senator Moore - Chair  
Senate Standing Committee  
on Community Affairs  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600

By Email: [community.affairs.sen@aph.gov.au](mailto:community.affairs.sen@aph.gov.au)

Attention: Mr Elton Humphrey

Dear Senator Moore

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

Please find Homebirth Australia's submission following. We would be happy to provide oral evidence to the committee.

Yours sincerely

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On behalf of Homebirth Australia

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## **Who Are We?**

Homebirth Australia (HBA) is the peak body for Homebirth awareness and promotion. HBA was established in 1980. HBA has midwife and consumer members with an executive of equal representation.

## **Our Aims**

- To support the rights of homebirth parents to choose how, where and with whom they give birth
- To increase public awareness and acceptance of homebirth.
- To provide communication and support to members of Homebirth Australia.
- To provide information to parents planning homebirth.
- To provide information, support and networking to service providers.
- To convene an annual national conference.

## **Recommendations**

**• Provide immediate professional indemnity insurance premium support, MBS funding and PBS access for 'eligible' homebirth midwives in private practice to establish parity with proposed Medicare reform.**

**• Establish a Government website that incorporates information with outcome data; to enable transparency and accountability for all maternity health professionals and assists women to make informed decisions about care providers.**

**• Provide funding for community education and awareness of homebirth as an option**

## Current Situation

The National registration and accreditation of Health professionals exposure bill requires all health professionals to provide evidence of indemnity insurance in order to be registered. Homebirth Australia believes this is an appropriate professional requirement. Since 2001, privately practicing homebirth midwives have been the only health professionals without indemnity insurance and have been consistently refused indemnity premium support.

Concurrently consumers of private homebirth have been treated as a 'de-facto class' of consumer with no realistic avenue of recourse in the case of serious injury as a result of negligence. Despite 8 years of advocacy on behalf of midwives and consumers the situation remains.

The legislation that is subject to inquiry by this committee will empower midwives to work to their appropriate level of education and registration, something they have long been denied. Whilst this is certainly a positive step in the reform process, disregarding funding and indemnity premium support for homebirth could have disastrous political consequences.

Two important points should be noted; whilst there is polarity of views regarding homebirth there has not been a campaign to make homebirth unlawful, rather a campaign not to fund it. We believe the potential unlawfulness of private homebirth to be an unintended consequence of the intersection of the Medicare related legislation and National Registration and Accreditation for Health Professionals draft legislation. It is in no-ones interest to force homebirth midwifery underground.

Homebirth Australia supports indemnity insurance for health professionals but contends that the product of insurance is not a measure of safe or appropriate practice; it is simply a measure for families to receive compensation after the event of proven negligence. This is supported by the fact the obstetric care and neurosurgery has been supported with insurance premium subsidy even though areas of 'high risk'. Actuarial advice and actual practice of homebirth midwives does not constitute risk beyond that of Obstetrics, where routine surgery, artificial hormones and pharmacological pain relief have the capacity to iatrogenic injury.

Australia's largest birth injury payout was the Calandre Simpson case, where on appeal, \$11M was awarded, see **(Appendix 1)**. Calandre has severe cerebral palsy as result of a hypoxic event. A possible cause of hypoxia could have been an overdose of syntocinon. Syntocinon is routinely used in obstetrics, and in our view not regarded as the dangerous drug it is. Over 40% of women receive syntocinon for either induction or augmentation of their labour. In many of these cases clinical factors would not support the induction or augmentation. There has been no such case for negligent practice from a homebirth midwife.

Minister Roxon seems to have responded to pressure from medical interest. She has not made a decision on the basis of available evidence or the declared rights of individual women. Unfortunately neither her office nor relevant bureaucrats have relied on current practicing homebirth midwives or consumers to gauge the level of risk and get a clear understanding of homebirth practice; both these parties have been shunned by the Minister's office and Department of Health and Ageing. Advice from the Minister's office is that an indemnity policy quote was received that was cost prohibitive. It is no surprise when there has been no interest in understanding homebirth practice, or consumer's perspectives around the perceptions of risk.

How can individuals who have no experience of, nor consult with any experts in the field make a decision? Obstetricians are experts in complicated pregnancies and related pathology. Midwives are experts in healthy pregnancies and the path of a normal labour and birth (Obstetricians do not attend labours for any great period of time, the vast majority of complications that establish in labour are detected and initially managed by a midwife).

## **Homebirth – International Perspectives**

If private homebirth midwifery is made unlawful, Australia will be out of step with the United Kingdom, New Zealand, Canada and The Netherlands.

In the UK, the College of Obstetricians and Gynaecologists and the Royal College of Midwives endorse a joint statement on homebirth, stating they

*“support home birth for women with uncomplicated pregnancies”*

In New Zealand there are no restrictions as to which women are eligible or not for homebirth. There are clinical guidelines, and midwives are required to provide appropriate clinical advice and documentation. Women, however, are regarded as sentient human beings and their informed consent is supported regardless.

In Canada midwifery regulation prevents a midwife from registering unless they are “competent and willing to provide care in a variety of settings, including home, birth centre and hospitals”<sup>1</sup>

## **Homebirth Options across Australia**

### **Current state funded services**

The option of homebirth is available to very few women, lack of funding and professional indemnity insurance for midwives are predominant factors. A small number of state funded homebirth models exist. Minister Roxon has handballed the implementation of homebirth to the states. This is un-workable. The states do not have the capacity to implement evidence-based homebirth services. Considering Medicare funding for midwives pushes maternity care further into the federal arena, there is clearly a financial disincentive as well.

Community Midwifery **WA** – 300 per year (*13.5 years established recently increased from 150*)

Darwin and Alice Springs - **NT**

Northern Community Midwifery

and Women's and Children's Hospital Program -**SA**

St George Hospital - **NSW**

(*3 years in operation, 50 accepted clients*)

Wollongong Hospital - **NSW**

(*12 months established have not accepted one client*)

Belmont Birthing Service- **NSW**

Tamworth Base Hospital - **NSW**

(*1 Midwife. Subject to refusal from one individual Obstetrician*)

No state programs exist in Victoria, Queensland, ACT or Tasmania.

Naturally these services operate in discrete geographical areas virtually all in metropolitan areas. Very few women are able to access them. In order to be established these programs also operate with strict exclusion criteria. Safety to mother and baby is paramount but exclusion criteria are often not about safety, merely custom and practice and accepted norms within Obstetrics. One must consider what this approach has given Australian women:

- ✓ A national caesarean rate of 32% and a raft of other medical interventions, many not based on sound evidence or clinical need
- ✓ A system that is centred around the needs of practitioners and organisations, rather than women
- ✓ Exceptionally poor post-natal care, especially within private obstetric models
- ✓ High rates of post-natal depression, the emergence of Post traumatic stress disorder
- ✓ High rates of morbidity (although not considered important enough to report nationally)
- ✓ A system of care with a high emphasis on clinical care and very little understanding or acceptance of the emotional needs of women or the life-lasting effects of poor care/birth trauma

Only the Darwin homebirth program accepts women who have had a prior caesarean. Virtually no continuity of midwifery models (providing hospital birth) accepts women wishing to give birth vaginally after caesarean (VBAC). A recent study in Canada showed that the risk of severe morbidity or mortality in VBAC women and their babies was about 1-2%.<sup>2</sup> To put this risk into perspective, women 35 years and over are routinely offered amniocentesis testing (a test to assess foetal abnormality). The risk of spontaneous abortion following amniocentesis is between 2 and 6%<sup>3</sup> this screening process is considered acceptable and little is mentioned of the risk of death to the baby. When risky procedures are part of medical practice they are accepted and defended. For procedures and choices outside of medical control there is a much different response.

Homebirth Australia maintains that exclusion criteria that sees women shunned from care, with a number choosing to give birth alone contradicts accepted and tested case law regarding informed consent and right of refusal and international conventions on women's rights.

### **Private Midwifery Care**

Midwives in private practice care for the majority of women choosing homebirth. Since 2001 these midwives have not been able to purchase professional indemnity insurance. Most health funds provide little if any rebates for homebirth care. In regards to maternity care Private health insurance is a 'closed shop' controlled by obstetrics. As such the majority of women choosing homebirth are required to fund it themselves.

### **Who Chooses Homebirth**

With a lack of funding homebirth is largely an option for those with the capacity to pay. The majority of women choosing homebirth are middle class. Despite the stereotype, many couples are highly educated, often legally or medically trained. When choosing to move outside 'accepted norms' you will find the majority of women/couples have engaged in considerable research and are highly informed about not only homebirth, but current practices in hospital birthing.

Another stereotype is that only 'low risk' women choose homebirth. Homebirth gives women a much greater chance of vaginal birth after a caesarean section (VBAC), likewise for women with a breech presentation or even twins. The domination of obstetrics has led a greater number of women to choose homebirth in these circumstances.<sup>4</sup> Even if homebirth midwifery becomes unlawful women are not going to necessarily change their mind. Hospital practitioners often refuse women their basic rights and feel they have no choice but to give birth at home.

**It is particularly concerning that poor hospital practices and clinician's attitudes remain unchallenged while the rights of women are further eroded**

### **Unassisted Birth**

It has been reported that there has been an increase in women giving birth without any health professional, often referred to as 'freebirth'. HBA has anecdotal evidence that supports this. Through our website we receive requests to source a local midwife. When midwives are not available, women often choose to give birth alone, rather than enter the 'system'. This is usually after a previous traumatic experience. The increase in freebirth is largely an indictment on a broken maternity system that is not based on evidence and is not woman centred.

**If private homebirth midwifery is made unlawful women will be forced to give birth at home alone, or with an unskilled birth attendant. This is not acceptable.**

### **Rights and Responsibilities**

Women's rights are human rights. Interestingly Australia was the one of the first signatories to the Convention against the Elimination of all discrimination against women. The Beijing declaration enacted in 1995 has become part of the convention. Clause 17 states

***“The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment;”***

We ask that you please examine how a persistent reply from Minister Roxon's office that there is 'no solution' to homebirth midwifery becoming unlawful accords with the above statement.

### **Indigenous Health and Homebirth – 'Closing the Gap'**

The Beijing Declaration includes a comprehensive Platform for Action and states

*109(j) Acknowledge and encourage beneficial traditional health care, especially that practiced by indigenous women, with a view to preserving and incorporating the value of traditional health care in the provision of health services, and support research directed towards achieving this aim;*

The maintenance and strengthening of homebirth midwifery provides Indigenous women with the best chance of culturally appropriate services, particularly 'on-country' birthing something Indigenous women have called for over many years. One of our greatest failings in child and maternal health related to Indigenous communities, and those at risk, is the continuance of obstetric dominated care.

On the other hand, midwifery care, combines clinical health assessments within a social

model. This approach is superior when attempting to address entrenched social dysfunction. This has been proven in remote Canada where a local community stood up and reclaimed birth in their local community (despite the nearest hospital being 5 hours plane journey when the plane could land on the ice)

Research from Northern Canada has shown that childbirth in very remote areas can offer a safe, culturally acceptable and sustainable alternative to routine transfer of women to regional centres; in spite of initial fears about safety and opposition to this service. In one community (Puvirnitug), a primary maternity service opened in 1985. Despite initially an eight hour plane trip (in ideal circumstances) to the nearest surgical services. Based on 3,000 births, the perinatal mortality rate has fallen and is better (9/1,000) than other comparable Indigenous populations, Northwest Territories (19/1000) and Nunavut Territory (11/1000)<sup>5</sup>

Additionally, comparing 1983 to 1996 statistics there has been a reduction in inductions of labour (10% to 5%), episiotomies (25% to 4%), transfers (91% to 9%) and the community has a 2% caesarean section rate (compared to the Quebec rate of 27%)<sup>26</sup>. Subsequently, other smaller, more remote communities (eg, Inukjuak: population 1,184) have commenced both on-site birthing and training of midwives. These communities continue to offer birthing services today as newer ones are being established. Seven years data from three remote communities is currently being analysed with preliminary results excellent.<sup>6</sup>

Reports from these communities describe a community development program that links the establishment of a local birthing centre to greater social functioning, a decrease in domestic violence and sexual assault and increasing numbers of men being involved in the care of their partners and newborns. The regaining of dignity and self-esteem has also been reported. A key factor supporting the change process appears to have been the open dialogue and debate around risk in childbirth with a recognition that:

“the cultural aspect of birth is not a mere ‘nicety’ that can be appended to the care plan once all other acute obstetrical techniques are in place. It is essential to perinatal health... it is from within the culture and community that real positive changes in the health of the people begins”.<sup>7</sup>

### **Informed Consent- A Poorly respected right**

Despite being a strong notion enshrined in law many practitioners providing maternity care does not understand or respect the notion of informed consent and right of refusal.

In QLD maternity staff believed a woman who was seeking a normal birth after 2 caesareans was going to give birth at home (after she failed to present for a scheduled 3<sup>rd</sup> caesarean, the only option provided). They informed child protection officers who then went to the woman’s home whilst she was in early labour. Incidentally this woman was not planning to give birth at home, she simply wanted her decision to give birth vaginally respected. Despite being in Queensland’s largest and only tertiary hospital her rights were not respected. This woman gave birth vaginally without complication at another hospital.

Earlier this year the Royal Australian And New Zealand College of Obstetricians and Gynaecologists (RANZCOG) released a statement regarding suitability criteria and referral between models of care, in respect to informed consent it states. <sup>8</sup>

“These guidelines acknowledge that a woman may choose not to follow a recommended course of action. In *some* circumstances, this will follow the provision of inaccurate or inadequate information. Subtleties of wording or emphasis can be critical in this respect. Where lack of “informed consent” is the reason given for non-adherence to guidelines, documentation should occur in a way that appropriate clinical audit is able to identify patterns of practice where this may be a repeated problem, perhaps reflecting the nature &/or method of information provision. Information should always be provided appropriate to the patients’ social and cultural

background, and in an unbiased manner. Written information is often helpful.”

There is no mention of the basic rights of women, nor is there an acknowledgement of ‘duty of care’ principles, that require health professionals to attend women and provide whatever care they are able to. This approach is legislated in the UK and Canada. Our reading of this clause suggests that RANZCOG is out of touch with the law and human rights. We hope that our legislators will not take the same approach. If private homebirth midwifery is made unlawful Australia will have something in common with Alabama in the US, where homebirth practice is illegal and capital punishment still exists

Homebirth Australia developed a document, *‘Homebirth Rights and Responsibilities’* (**Appendix A**) some 20 years ago to empower women and midwives when deciding to give birth at home. In the hospital system women still present with a ‘birth plan’, sadly these are often ignored or worse mocked. The on-going impacts of treatment at birth are not recognised. Women return home and become invisible, their pain and suffering is usually silent. The act of giving birth is the most important physical and emotional event in a woman’s life. Her experiences of birth will be carried with her for life. The impact of poor care can heavily influence parenting and the well being of the whole family.

## Quality and Safety

The safety of homebirth has been a hotly debated topic in Australia for some years. Perhaps the debate has been fuelled by the fact that journalists turn to those who benefit the most from maintenance of the status quo, obstetricians in private practice. If journalists quoted used car salesmen as reliable sources for buying a second-hand car as opposed to a new one, the public would question the reliability of the information. The power of the medical lobby and the ‘blind faith’ largely commanded from consumers has enabled a campaign of misinformation and prejudice.<sup>9</sup> In recent times this blind faith has been exposed by the alleged assaults on women by Dr Graeme Reeves and Dr Roman Hasil, both Obstetricians.

Community organisations such as ours have known of many stories similar to these (perhaps not as gruesome as some of the alleged assaults of Dr Reeves) for many years. Women have been dissuaded and even threatened from complaining. For those who persevered the majority were met with red tape and obfuscation, some with counter-allegations, questioning the integrity of the complaint.

Supporters of homebirth are not blind to research evidence or principles of safety and quality in modern health care. There is a wealth of evidence proving Homebirth to be as safe if not safer than hospital birth for women with ‘low-risk pregnancies

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If we consider that normal physiological birth is the safest way for a baby to enter the world for both mother and baby, then the results of Johnson and Daviss<sup>44</sup> study show that birth at home is safer than birth in hospital for women with a low risk of complications. The outcome of their study showed that,

**“Planned home births with certified professional midwives had similar rates of intrapartum and neonatal mortality to those of low risk hospital births; medical intervention rates for planned home birth were lower than for planned low risk hospital birth.”**

This study required all North American certified professional midwives to furnish their statistics for all births in order to maintain registration. Interestingly, the sample included women that



would not be considered low-risk by obstetric measure (breech presentation, twins and vaginal birth after caesarean).

It is time to acknowledge that 'risk' is not purely a clinical science. The whole being of a woman must be considered. Currently there is little if any acknowledgement to psychosocial factors that increase or in fact reduce risk. It is understood that midwives providing homebirth services would work within guidelines for consultation and referral (such as the Australian College of Midwives Consultation and Referral Guidelines).

It is also necessary that medical staff reciprocate collaborative practice. The Maternity Services Review (MSR) has become the *midwifery services review*. Why has obstetric practice not come under the microscope? The safety of women and babies should not come second to the powerful lobby of the medical profession.

All health professionals must have high levels of accountability and demonstrate safe practice. This approach will enable a safe system for all. It is imperative that these guidelines include very clear pathways for women to give informed consent and conversely have the right to refuse.

As part of the MSR roundtable meetings a leading Obstetrician publicly announced that he would be "loathed to see a woman have the final say in her care". This is a prevailing attitude, it is paternalistic at best, dangerous at worst. It also contradicts the fact that as a mother, a woman will make thousands of decisions about her child's welfare over their life. Why then is she so disempowered at the time of birth?

**In Australia today, a woman has the right to terminate a pregnancy and yet through obstetric dominance that same woman's rights are reduced considerably in childbirth.**

## **Evidence based practice and the homebirth model of care**

### **Continuity of carer**

The homebirth model offers continuity of carer throughout the childbearing year. There is mounting evidence, which suggests there are clear benefits for women, and babies who receive this type of care. The research suggests that women experience shorter waiting during the antenatal period, they are more likely to attend prenatal classes; they feel more prepared and experience less interventions during labour and birth. There are also many benefits in the postnatal period with greater rates of maternal satisfaction, the ability to discuss post-partum problems, debriefing the experience with the midwife who was present at the birth and feeling more prepared and confident with baby care and parenting skills.<sup>45</sup>

### **Women's autonomy and control**

Lock and Gibb<sup>46</sup> found that women who birthed in their own environment felt more secure and more supported than those that birthed in hospital. The hospital setting was seen as a place of discomfort, both aesthetically unappealing and strange and uncomfortable with perceptions of it being a place for the sick. In comparison the home was seen as a place of comfort, familiar and quiet that made a considerable difference to the woman's emotional state.

### **Home to Hospital – Crossing the Great Divide**

For safe practice it is essential that homebirth midwives have clinical privileges to local hospitals, this has been ignored and refused by Governments and bureaucracy. Currently both women and midwives are often greeted with hostility and 'made to pay' when transferring into hospital. Clinical privileges will enable a seamless transfer into hospital when required. Midwives will also need to order routine pathology tests and prescribe essential drugs for labour and birth at home. Including homebirth within the 3 bills under Senate examination would serve this purpose. Women have reported great difficulties in accessing essential tests and or drugs for homebirths. Often they are required to attend a GP and request a prescription (eg Vitamin K). These requests can be met with hostility and even refusal.

If the safety of mother and baby is paramount then there needs to be real progress made to work in a collegiate manner. The ALSO course promotes this for multi-disciplinary teamwork in emergency situations. A real team approach that acknowledges the right of women to choose both their carer and birthplace needs to be promoted to maximise safety and quality.

### **Community Awareness and Education**

Homebirth is currently not a mainstream option. With education and awareness, alongside funding and insurance protection, more women will choose a midwife and may choose to give birth at home. There is considerable scope to improve outcomes, save money and reduce hospital bed day stays. Women need to hear from other women who have given birth at home and enjoyed midwifery care. Pregnancy and childbirth is not expressed positively in mainstream culture. A huge industry is reliant on women needing assistance, and their marketing techniques undermine the ability most women have, to give birth and feed their babies with minimum intervention. In order to make lasting change, the Government needs to fund consumer groups to lead education and awareness campaigns to help inform and support choice in childbirth.

### **Vision for the future**

Women continue to choose homebirth and always will. The current discrimination that sees our tax-base fund a very expensive private obstetric option while women choosing homebirth have no funding recourse or even the protection of an insured midwife is patently unfair. Now women face that choice becoming unlawful. As tax-payers, families choosing homebirth have funded the unsustainable Medicare Safety net (where Fees by obstetricians have rose by close to 300% in a period of 4 years)<sup>4748</sup> and then fund their own health care. Women and their families must be brought to the centre of maternity care.

Dr Lesley Russell a former adviser to ALP Politicians and now a fellow with the Menzies Centre for Health Policy made the following comments during the Maternity Services Review last year<sup>49</sup>

*“ Improving the current provision and funding of maternity services is imperative. It will require strong leadership from government and strong voices from the community.”*

Minister Roxon must be commended for taking the step that no other Health Minister has. She has acknowledged the importance of providing women with choice. It is not advisable to only provide choice that is palatable to medical lobby groups. The Maternity Services Review received a staggering 950 submissions. 53% of the MSR submissions were related to homebirth. To put this in context the National Health and Hospital Reform Commission just over 500. . Unfortunately it has come to our attention that senior bureaucrats have belittled

these submissions in an attempt to defend the MSR position not to fund or provide indemnity premium support for homebirth.

### **The Way Forward**

The current dilemma of hoping women will stop choosing to birth at home and this problem will simply evaporate is not realistic. A growing number of women are very committed to giving birth at home. Sadly some of these women are refugees from the hospital system, determined never to return. Our broken maternity system needs a major overhaul. Minister Roxon made positive and determined steps to enhance midwifery practice consistent with education and registration standards. Unfortunately she has yet to address medical dominance in maternity care. If Australia is to acknowledge the inherent rights of women to determine all aspects of health care funding and indemnity assistance for private homebirth care must be made available. By doing this Minister Roxon will make a clear statement that individual women are at the centre of Australian maternity care, not vested interest groups.

# Medical Indemnity in Australia: How one birth changed maternity services

Justine Caines reveals how one birth changed the medico-legal climate of birth care in Australia.

As a consumer advocate, I have long had an interest in medical indemnity. As I'm a homebirth mum who takes full responsibility for her body and that of her baby, some find this strange. In order to successfully engage with government, one needs to understand the current climate in order to achieve midwifery reform. I believe the view that professional indemnity insurance is not important is misconceived. Over many years I have seen it being the key to reform.

I was changing my second child's nappy in 2001 when my midwife called to say she was to 'lose' her insurance. Clancy is now 7.5 years old. As you all know, despite hundreds of millions of dollars in rescue money to Australia's medical profession, not one cent has been afforded to midwives.

## The Case of Calandre Simpson

Many know the collapse of medical and professional indemnity was largely a result of global factors, namely the demise of large re-insurers after September 11, 2001. Interestingly, the decision by Guild Insurance to no longer offer a policy to midwives happened before this. Their reasoning, that the midwifery pool was too small, was justifiable. The fear of a major payout for catastrophic birth injury proved correct. In November 2001, the NSW Supreme Court awarded Calandre Simpson \$14 million dollars (The award was reduced on appeal to \$11 million). At that time, the \$11 million award was twice that of the next highest payout. This payout assisted in the collapse of Australia's largest medical indemnity organisation, United Medical Protection (UMP), and brought with it what we know as the 'medical indemnity crisis.'

Of particular importance is the 'care' received by Calandre's mother. It was proven that she was given an overdose of Syntocinon (a drug used for induction and augmentation of labour), as part of an induction. Five attempts at forceps were tried and finally the mother had a caesarean section before Calandre was born with severe Cerebral Palsy. It was concluded by the court that the Syntocinon overdose could have caused the Cerebral Palsy, before the attempted forceps delivery.

Before I look at what has unfolded, it is prudent to note that the Simpson family had considerable resources, far in excess of the majority of Australian families. This enabled them to fund a nine-year legal battle. It also contributed to the high cost

of the claim as the family's lifestyle was considerably more affluent than most.

The other interesting point is that, although this case essentially toppled the medical indemnity industry, little has been learned. The practice of performing a caesarean section rather than forceps is likely to have increased. The incidence of induction and augmentation of labour using the drug Syntocinon has not reduced. According to the Australia's Mother's and Babies 2005 report (AIHW, 2007), 44 percent of women are having Syntocinon for either induction (25 percent) or augmentation (19 percent) of labour.

“

Providing indemnity cover would demonstrate a fundamental commitment to maternity reform. It would also enable midwives to take their rightful place as the experts in normal birth.

The opportunity for error is therefore high. In essence, despite hundreds of millions of dollars in taxpayers' money being spent on medical insurance rescue packages, obstetric practice has largely remained unchanged.

## The Truth About the Rescue Packages

In 2001 and 2002 the Howard Government sprang to action. Despite Midwives being precluded from the 'Indemnity Summit' and any indemnity protection, a raft of measures were introduced, at a cost of \$160-180 million per year. (Commonwealth Government of Australia, 2007a)

One of the key reforms was the introduction of the Policy Support Scheme (PSS), available to obstetricians, neurosurgeons and rural procedural general practitioners (GPs).

*Under the PSS, if a doctor's gross medical indemnity costs exceed 7.5% of his or her*

*gross private medical income, he or she will only pay 20c in the dollar for the cost of the premium beyond that threshold limit. In other words, the PSS meets 80% of the premium above the 7.5% threshold of an eligible doctor's gross private medical income. (Commonwealth Government of Australia, 2007a)*

Rural procedural GPs are eligible for PSS support regardless of their income.

Other policy protection measures include the High Cost of Claims Scheme. This scheme reimburses insurers for high claims costs. The Exceptional Claims Scheme provides 100 percent assistance to claims resulting in awards greater than \$20 million.

## The Bolam Test

In addition, the Ipp Report (Ipp, 2002) made recommendations for considerable Tort Law Reform (the law governing personal injury negligence). Part of this reform was to, by statute, implement a modified version of the 'Bolam Test'. In at least NSW and QLD:

*The standard of care will be that determined by the court with guidance from evidence of acceptable professional practice unless it is established (in practice, by the defendant) that the defendant acted according to professional practice widely accepted by (rational) peer professional opinion. (Dobler v Halverson, 2007)*

Considering many obstetricians engage in practices that are not based on evidence, this is deeply concerning. A relevant example could be anal/sphincter damage created from an extended episiotomy. The evidence regarding episiotomy effectiveness may assist a consumer in mounting a claim. Under the 'Modified Bolam Test,' however, if the subject practitioner gathered other specialists who agreed they would also perform an episiotomy, the injured woman could be unsuccessful.

The Australian Plaintiff Lawyers Association stated in a submission to government:

*APLA is concerned that doctors already hold a privileged position in our society and are treated differently to other groups, including other professions. Patients' rights should not be compromised for the sake of doctors' hip pockets. (APLA, 2003)*

## The Indemnity Crisis Myth

Despite such comprehensive support and reforms for the medical profession throughout this time, the Australian public endured hundreds of media stories, transforming the spin of self-interest into an art form. Many in the community



The numbers of private midwives have been greatly reduced, with no Government action to resolve the situation. This leaves most women with no choice but to enter the hospital system to have their babies.

would still believe that the reduction of maternity services is as a result of skyrocketing insurance premiums directly impacting practitioners; a direct result of an over-litigious society. This could not be further from the truth. Medical practitioners have been very well protected, whilst consumer rights have shrunk and the continuation of a totally anti-competitive maternity health system has resulted in a reduction of services and arguably quality and safety for women and babies in rural and metropolitan Australia.

During this time I canvassed these views with several journalists. I even raised evidence of 'double-dipping'. Whilst private obstetricians were receiving the benefits of the PSS scheme some were also charging women an insurance fee of up to \$1500. Sadly there was little interest in covering this story. I believe that lazy journalism continued to perpetuate the myth of an 'indemnity crisis' for several years.

### Outcomes for the Midwifery Profession

The most obvious outcome of the refusal by the Federal and State Governments to assist with midwives indemnity insurance has been a great reduction in the numbers of privately practicing midwives. Alongside this, very few private health funds provide a midwifery/homebirth benefit. Of those who do, most do not provide a benefit on par with obstetric pay-outs.

The advent of the Bachelor of Midwifery was very positive. Practical experience, however, has been severely restricted. Students are unable to gain experience with homebirth midwives; rather, they experience the highly interventionist

'system'. It would seem the theory of educating a midwife to work in continuity and community models is of little use when the majority of students are unable to complement this learning in practice.

Access to Medicare provider numbers (or a national funding arrangement) is impossible without indemnity. There is, however, no impediment for the Rudd Government to include midwives in the PSS. Some positive comments have been heard from Health Minister Nicola Roxon (in media interviews and releases since the election). However, providing indemnity cover would demonstrate a fundamental commitment to maternity reform. It would also enable midwives to take their rightful place as the experts in normal birth.

### Consumers Silenced

Consumers have again been silenced in this debate. Most states and territories have legislation that makes professional indemnity either compulsory or a central component of registration. In NSW, The Health Care Liability Act was instituted in 2001. The explanatory memorandum stressed the importance of consumer protection. Interestingly, the rights of Australian women choosing private midwifery care don't have the same value as those women choosing the services of a specialist obstetrician or a procedural GP. When I challenged the legal branch of NSW Health with this comment I was greeted with silence.

Another contentious issue that has surfaced since the loss of indemnity insurance is the establishment of publicly-funded homebirth services. Whilst my socialist heart leaps for joy that women can access the care of a known midwife and the option of homebirth without cost, fundamentally these programs are flawed.

They all exist with rigid guidelines and on the back of the benevolence and goodwill of obstetricians. Some of these individuals are truly wonderful and their practice most progressive. The premise, however, that midwifery practice can only exist on the say so of the medical establishment is dangerous.

Surely the central tenet of maternity reform is to establish a midwifery scope of practice that enshrines the appropriateness of midwifery care based on education and registration. It must also enforce the very heart of midwifery, 'being with woman' and as such the relationship between a woman and midwife. This, in turn, would help establish the rights of women to make choices around how, where and by who their bodies are or are not handled.

Whilst the catastrophic birth injury of Calandre Simpson is tragic, the impact of her court outcome has not been critically analysed. The whirlwind of risk management and defensive practice that has followed was not justified.

Calandre Simpson was a 'veritable needle in a haystack,' a terribly injured person as a result of negligence, from a family of considerable means able to fund expensive litigation. Instead of looking at what constitutes negligent practice and rewarding its reduction, the federal government chose to remove the rights of consumers, protect the pay packets of medical practitioners and deny midwives their rightful practice.

\*All current assistance from the federal government has been in the form of medical indemnity. Midwives have sought professional indemnity and with their inclusion in any government scheme, such a term would be more appropriate.

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### About the Author

Justine has been a driving force in maternity reform since 2000. She is a former National President of Maternity Coalition, current Secretary of Homebirth Australia and convenor and founder of the political party, What Women Want (Australia). Most recently she established a communications consultancy business. Mother of seven all born beautifully at home. She lives in rural NSW which she considers challenging.

## THE PREGNANT WOMAN'S HOMEBIRTH BILL OF RIGHTS AND RESPONSIBILITIES - HOMEBIRTH AUSTRALIA

*There will always be an element of risk in birth whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which should enable a woman to give birth at ease with her environment, her attendants and herself.*

*No professional, however well-meaning, will have to live with the consequence of the outcome of labour and birth as long or as intimately as the consumers to whom they offer their services. The choice of birth professional is possibly the most important choice a woman will make during her pregnancy. There is no place for paternalism in the practice of obstetrics although at some stage of labour the decision may be made to place the management in the hands of the professional. However, domiciliary obstetrics is the 'art of invisibility' and without complications a woman gives birth herself, supported and aided by her midwife.*

*This most important choice of birth professional should be made after long and careful evaluation of the practitioners available. It is especially helpful to talk to as many clients as possible and get a clear picture of the mode of practice. Every woman gives birth in her own individual style and will feel easier if her practitioner's style suits her own. Some homebirth midwives collect statistics of the incidence of complications which occur within their practice, such as caesarean sections, episiotomies and tears for on-going review of their own work.*

*Expertise in decision making is based on a firm grasp of the possible options, their consequences and their relative risks. This is only possible within the context of a mutually trusting and warm relationship. The complexities of birth and death call for hard logic, love, courage, deep conviction and intuition.*

*Childbirth thus becomes a shared adventure between parents and professionals. The rights and responsibilities of all concerned should be thoroughly discussed and scrupulously observed. In this way, the self-esteem and autonomy of women, whether as birth-giver or midwife, will be enhanced whatever the physical outcome of the birth.*

*The arduous and often unrecognised role of the homebirth midwife has become politicised because of the support midwives give women in their efforts to regain autonomy in birthing. She and her family often suffer considerable personal and economic hardship as she may work outside the mainstream of obstetrics due to lack of peer support. With the widespread misconceptions about the safety of homebirth, her professional status is in jeopardy if anything goes wrong. However skilled she may be, deregistration and loss of a career is a constant insecurity in the face of social hostility to her chosen mode of practice.*

## **The Pregnant Woman's Homebirth Bill of Rights.**

1. The pregnant woman has the right to choose her place of birth.
2. The pregnant woman has the right to choose her birth practitioner and to be fully informed of her practitioner's qualifications and experience.
3. The pregnant woman has the right to choose who will be present at her birth and the right to refuse entry or to ask anyone to leave her place of birth.
4. The pregnant woman has the right of access to literature and information about birth and particularly homebirth.
5. The pregnant woman has the right to know her practitioner's methods and techniques of birth.
6. The pregnant woman has the right to know the approximate costs which will be incurred under her practitioner's care.
7. The pregnant woman has the right to expect that any information she gives her practitioner will be confidential and not divulged to anyone else without her permission.
8. The pregnant woman has the right to comprehensive antenatal care including access to standard tests and procedures related to the well-being of mother and child.
9. The pregnant woman has the right, prior to the administration of any drug, medication, procedure or test, to be informed by her practitioner of any direct or indirect effects, risks or hazards to herself or her unborn or newborn baby.
10. The pregnant woman has the right to determine for herself whether she will accept the risks inherent in a proposed therapy, drug, test or procedure.
11. The pregnant woman has the right to choose how she gives birth and to be treated with dignity and consideration at all times so that she feels free to follow her instinctive reactions during birth.
12. The pregnant woman has the right to ancillary medical support when needed.
13. The pregnant woman has the right, if transferred to hospital, to be treated with respect and courtesy and to be accompanied by her practitioner and support persons of her choice.
14. The pregnant woman has the right, if transferred to hospital, not to be separated from her baby except for valid medical reasons.
15. The pregnant woman has the right to comprehensive postnatal care including support for the establishment of breast-feeding, assessment and care of her newborn baby, and information about relevant screening tests and registration of birth.
16. The pregnant woman has the right to be informed if there is any known or indicated aspect of her or her baby's care or condition which may cause her or her baby later problems.
17. The pregnant woman has the right of access to her and her baby's records and to receive a copy of her notes when desired.
18. The pregnant woman has the right, in the event of an unexpected outcome to her pregnancy or birth, to receive all the additional support and services that she needs.
19. The pregnant woman has the right to complain and to receive satisfaction from her practitioner

*As the pregnant woman has rights, so she also has responsibilities.*

# The Pregnant Woman's Homebirth Bill of Responsibilities

1. The pregnant woman is responsible for learning about the physical and emotional process of labour, birth and postpartum recovery.
2. The pregnant woman is responsible for learning about good antenatal and birth care so that she may choose the best possible arrangements which suit her individuality and circumstances.
3. The pregnant woman is responsible for learning about her practitioner's methods including evaluation of statistics of past cases and talking with other clients.
4. The pregnant woman is responsible for her own emotional and physical well-being during pregnancy.
5. The pregnant woman is responsible for attending her antenatal appointments and informing her practitioner if she is unable to attend.
6. The pregnant woman is responsible for her own psychological preparation for homebirth in a society which may be unsupportive or even hostile, especially if the pregnancy results in the death of a baby.
7. The pregnant woman is responsible for meeting her practitioner's requirements for preparation for homebirth.
8. The pregnant woman is responsible for informing the practitioner of any relevant physical, emotional or psychological information which may affect the outcome of her birth. These may include intake of drugs, medications, herbs, allopathic, naturopathic, psychological or alternative therapies and the obstetric, sexual or psychological history of herself or her relations, friends or partners which are affecting her attitude towards birth and parenting.
9. The pregnant woman is responsible for providing a suitable birth place and environment for her newborn.
10. The pregnant woman is responsible for making any alternative arrangements for her birth and for booking into hospital.
11. The pregnant woman is responsible for making mutually agreed upon birth plans with her practitioner in advance of labour.
12. The pregnant woman is responsible for choosing a suitable support person or persons for her birth and for ensuring they are emotionally and psychologically prepared for their role at her birth.
13. The pregnant woman is responsible for being assertive enough to dispense with any person who is not supporting her during her labour.
14. The pregnant woman is responsible for ensuring her support people can carry out her preference if she is unable to express them during labour.
15. The pregnant woman is responsible for the psychological and emotional preparation of siblings for the birth.
16. The pregnant woman is responsible for the choosing of individual support people for siblings.
17. The pregnant woman is responsible for acquiring information about breast-feeding and care of the newborn.
18. The pregnant woman is responsible for arranging domestic support for herself and her family during the postnatal period.
19. The pregnant woman is responsible for obtaining information regarding the cost of her care and making arrangements for payment.
20. The pregnant woman is responsible for evaluating the quality of care she has received and making any dissatisfactions she may feel known to her practitioner.

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