Melbourne Midwifery

Specialist Services Pty Ltd abn 34 007 423 994

Robyn Thompson
Registered Midwife
Breastfeeding Consultant
Maternal & Child Health Nurse
Registered Nurse
BAppScAdNrsg
PhD Student
NB VIC Reg 29186

PO Box 247
Altona VIC 3018
Australia

Private Midwifery Practice
Pregnancy, Birth & Breastfeeding Consultancy

midwife@bigpond.net.au
www.melbmidwifery.com.au

Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee
E-mail: community.affairs.sen@aph.gov.au

July 15, 2009

Dear Senator Moore

Thank you for the opportunity to write this submission, to share the reality of private midwifery and express my concerns about the above bills. I support that Medicare funding, limited prescribing rights through access to the Pharmaceutical Benefits Scheme (PBS) and professional indemnity premium to be included for midwives providing care for women to give birth in hospital.

The government is to be commended for the hard work that has resulted in introducing Medicare funding for midwifery care and for creating equality for all Australian women. However I am concerned about tarnishing such progressive steps by excluding funding for indemnity arrangements for the choice of homebirth. In the presence of such major advances, preventing women and midwives from participating in homebirth is unacceptable.

Government discrimination against one profession (midwifery) is incongruent with a woman's natural law right to give physiological birth at home in the presence of a qualified midwife. Physiological birth is a mammalian event. Private practice midwives privy to these natural experiences find it hard to convey the extreme power a woman self engages, during her labour and birth without medical, surgical or pharmaceutical assistance. Quietly observed and carefully monitored, she is not reliant on other types of management during her toil, see article, Northern Territory News Article "Embrace the pain of birth", http://www.ntnews.com.au/breakingnews/. It is reasonable to protect the woman's natural law right to maintain personal control over her decisions including transfer to hospital/medical care. Care and surveillance by an experienced midwife at home is far safer than a woman birthing on her own. In David Attenborough's words, the womanly ability to birth her baby is truly "one of nature's greatest events".

Yours sincerely,

Robyn Thompson
RM, RN, M&CHN, BachAppSc, BF Cons
PhD Student
Charles Darwin University NT
Mob: 0418 324 058

Submission to: Inquiry into Health Legislation Amendment

(Midwives and Nurse Practitioners) Bill 2009 and two related Bills

This submission is purposely aimed at providing comment from the perspective of an experienced and responsible midwife (elder). There are already many submissions identifying current research evidence for the safety of homebirth. This submission specifically offers an understanding of how private midwifery practice is conducted. The comments provide information to the provision of safe, quality, continuous midwifery service for women and newborns from early pregnancy, right through to the sixth postnatal week. To support this submission a synopsis of my professional background is included (see Appendix 1). As a Director on the Australian College of Midwives Board http://www.midwives.org.au/ I am also involved in writing the College submission.

Appeal

First I appeal to the Australian public servant advisors, decision makers and the health Ministers to responsibly ensure equal time for fair and reasonable representation to the voices of midwives and women on the issue of Australian Private Midwifery practice and homebirth. The Australian Private Midwifery Association (APMA) http://www.privatemidwives.net/ is a recently formed umbrella association to collectively unite the various private midwifery practice groups across the Australian states and territories.

Self employed midwives

Self employed (private practice) midwives evolved because of the request of Australian women to experience the full scope of midwifery practice with the same midwife across the whole maternity episode including up to six postnatal weeks. Responsible, safe, midwife services in the home, are personalised to meet individual needs. Women's time is valued, they are not kept waiting and the maternity service includes the whole family and significant others. Australia relies on private enterprise in many sectors including other professions. Australian democracy ensures its citizens have the right to employ a diverse range of private services and until now it included private midwifery services.

Indemnity withdrawal

Specifically I bring to the attention of the Australian Health Ministers' Advisory Council of the impact that the withdrawal in 2001 of professional indemnity had on my responsible private practice and point out that the same principles apply to the private practice of midwifery colleagues. I had successfully negotiated visiting access as a primary care midwife in the private and public hospital systems. This access was removed once the elimination of insurance announcement was made. There was no consultation; I was informed by letters from the various organisations. Obliged to the principle that women have the right to decide their personal birthing choices and the belief that midwives had the right to practice their skill in any setting according to the International Definition of a Midwife (see appendix 3) was why I made a conscientious decision to take the risk and continue my service without indemnity insurance that provides public protection. This situation for many midwives was untenable for many who withdrew their services leaving a void of experienced midwives in the workforce. The unsolicited demand for my

service has continued for example, (see appendix 11). I receive at least two emails &/or telephone calls a week from women requesting private midwifery services to birth at home.

Brief Scenario of normal events in private midwifery practice

General idea of time frame: Antenatal consultations are generally one hour duration plus travel time, education and information during this time. Postnatal visits 1 -2 hours plus travel time, labour and range birth between 12 -24 hours average 15 hours (obviously this has individual variables). Between 2-4 hours postpartum (immediately after birth, until the first breastfeed is completed average 2 hours) and mother and baby are fed, mother showered and settled, ready to sleep.

The most common event at point of entry to private midwifery service is when women makes contact, generally by word of mouth referral or own her research. Generally a request for an appointment is made to discuss her plans to homebirth. On initial presentation the stories for seeking homebirth services are varied, many are related to women having emotionally or physically traumatic previous hospital experiences.

Documentation and Service

Information exchange includes the pros and cons of birthing at home and in any other setting. Time is spent answering the woman and her companion's queries and directing them to various resources on the range of pregnancy and birth information and options and available evidence. Most midwives have a lending library of books, audio visual education information and a range of relative hand outs. The focus of the visits is on the individual needs of the woman and her family. A request to employ the midwife services may be arranged at the first visit or second visit.

History sharing and other information

Receiving, giving and documenting information is a mutually agreed process that is continuous at each visit, the following is a basis for understanding some of the exchange that occurs between a woman and the private midwife:

- Generally important history information is shared and recorded at this first or second visit. Such information is essential to the initiation of a trusting relationship and guidance of the partnership arrangement for care and service provision
- Discussion includes the availability of community and hospital access to medical services, pathology and other appropriate services
- Any issues around personal history, previous surgical and medical and pregnancy history, obstetric, midwifery and gynaecological history, previous pathology results, previous serious illness, known allergy knowledge particularly to medications and foods
- Menstrual history and calculation of estimated date of the coming birth from last normal menstrual period or conception date. History of previous pregnancies or births, duration of pregnancy, birth outcomes, duration of labour, duration and term of breastfeeding, including any experience of previous breastfeeding

complications. Information about previous miscarriages, terminations of pregnancy or other relevant information such as IVF pregnancies, episodes of post partum haemorrhage, anything relevant to pregnancy, labour , birth and postnatal

- Previous pregnancy/birth and family birth history, mothers, grandmothers, sisters. Congenital abnormalities discussed and recorded
- Questions women commonly ask are about their right to refuse fetal monitoring; they are especially concerned about being confined to a bed with attachments to their body. Artificial rupturing of membranes and the number of vaginal examinations and going past estimated 40 week gestation are other common questions. They may also talk about fears of their baby have scalp electrode inserted for internal monitoring of the baby. Another concern is about the freedom to move about in labour and the use of water submersion in labour for pain relief and most ask about Waterbirth
- Pre arranged hospital back up booking and possible transfer in pregnancy, labour or postpartum arrangements are explained from a safety and efficiency of transfer perspective
- Financial arrangements are generally discussed, unless previously discussed by phone. Financial arrangements are tailored to meet individual requirements
- Information about the various recommended tests and antenatal assessment such as blood pressure reading, baseline pulse, clinical evidence of pregnancy anaemia (signs and symptoms) GBS, Ultrasound, routine pathology, RH negative blood group, explanation of normal antenatal care and assessment, diet, rest and exercise
- Information exchanges about morning sickness, baby (fetal) movements, maternal intuitiveness and the heightened emotion and excitement around pregnancy. Children are welcome at these visits, they are included in and excited about the baby assessment
- Details of preferred medical support is discussed, names and contact details of a local GP or previous obstetrician and birth place (if applicable) is recorded. All of the above and more are documented in the woman's personal file. She is offered and elects whether or not to carry her own share-care record in the event she has consultation with other professionals or if she chooses to write in her own record
- Women are informed about and directed to the Privacy Act, information about their legal rights, the midwives legal requirements and the protocols and systems for complaints
- Handouts are given on various matters such as Vitamin K for the newborn, GBS swabbing of the newborn, third stage passive and active management
- Midwives explain the birth, resuscitation equipment and drugs they carry. Women are informed as to why their consent is required for any procedure and administration of drugs such as oxytocin in the event of postpartum haemorrhage. They are informed of the type, amount, recommended route, known side effects of the drug
- They are informed of their right to refuse
- Adult and neonatal resuscitation procedures explained
- Fetal growth and maternal wellbeing is assessed at each antenatal visit

- Other matters covered in subsequent visits are about perineal preservation, breastfeeding, surgical births, onset and progress of labour, spontaneous rupture of forewaters and colour of liqour, pain relief and epidural anaesthesia, newborn assessment survival skills and reflexes.

Labour and Birth

Labour is generally a spontaneous (natural) onset between 38 and 42 weeks gestation. Most women establish in labour as the sun descends they may have been contracting over the day, establishing in labour is common at this time of the evening. The woman calls to inform me when she is contracting regularly and other agreed reasons such as rupture of forewaters. Once her labour establishes, I/we are present in the woman's home observing, assessing, documenting and encouraging her through any hurdles she may experience in her labour. Nearer second stage an associate midwife may be called to assist the primary midwife, personally I find this helpful. I am aware that other colleagues are just as comfortable working without the assistance of an associate midwife. The reasons I think the presence of an associate midwife nearer second stage is valuable in the event of an unexpected situation such as the need for resuscitation or post partum haemorrhage. Thankfully in my practice these events are rare but being prepared is a good motto and certainly has advantages. One of the reasons I believe that all women should know a second midwife is in the unlikely event of sudden illness, accident or even death. If the primary midwife is unable to attend under these circumstances, respect for the woman's labour and birth plans is not disrupted and she is most likely to continue in her home with a known midwife.

Evaluation (Client, Self and Professional)

Private practice midwives participate in several areas of evaluation. For example: Written client evaluation received is almost always positive, women and family feedback n the areas of antenatal, labour, birth and postnatal care assists the way in which we drive our practice. Most women who employ our services return for future pregnancies. Self evaluation and reflection assists in improving day to day practice and guides you in areas that may need current updating by participation in ongoing education. Professional evaluation via the Australian College of Midwives – MidPlus Programme, drives a tri-annual Midwifery Practice Review (MPR). The ANMC Framework guides the preparation for this review. This rigorous evaluation takes about three months to prepare. Midwives, who take this avenue, maintain continuing credit points (CPD) for ongoing education in various practical, professional and academic settings. Midwives completing their MPR also participate in a face to face interview with two unknown qualified reviewers (one a consumer, the other a midwife). Review of your presentation and questions are exchanged and reflection of future direction is future direction/s discussed. The MPR process is evaluated to ensure the criteria is professionally appropriate and updated. I look forward to my next MPR evaluation is due in 2010.

Education, Information and Documentation

Education, information and documentation continue with every visit, generally in the woman's home. Because I live near the beach, often women will elect to have some antenatal visits at my home based rooms, so they can take the other children to the beach. When the contract is agreed the midwife is available for the woman until the sixth postnatal week and can be contacted any time. Maternal health and wellbeing, fetal growth and movement, evaluation of any issues that my need consultation with another professional, repeat pathology if required, emotional and psychological progress, general health and plans for breastfeeding. In my experience, almost all

women who birth at home elect to breastfeed and very few experience breastfeeding problems. The woman's plans for her special birth are developed over the pregnancy and some women have returned for six pregnancies.

Indemnity Insurance

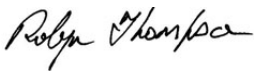
Indemnity insurance remains elusive to midwives, the only profession unable to access insurance and this has continued now for eight consecutive years. If indemnity insurance was the requirement for all midwives regardless of where they practice and the emphasis on reliance on employee vicarious liability was diminished there would be the numbers for insurers to indemnify all midwives. Vicarious liability itself is inadequate when the employer retains the right to counter sue the employee for costs incurred for proven negligence or a large payout.

Conclusion

This persistent insurance dilemma for over 200 responsible midwives has denied them their right to practice their professional skills. Some have claimed their right to continue to practice in the face of adversity. Under the current Australian situation women are denied access to the full range of cost benefit, continuous midwifery services across the full scope of practice. Women in local communities are denied access to a range of quality midwifery service options and some are forced into systems or choose to birth at home alone. Homebirth will not go away because private midwives are denied their right to practice, homebirth has been around for centuries and will remain for centuries to come.

My request for the government, the ministers and the advisors is to take equal time to seriously listen to privately practising midwives who provide cost effective and safe services for women in their homes. To reconsider how professional indemnity insurance can be applied to all midwives with jurisdiction requirements and professional requirements expected and recommended by the Australian College of Midwives.

Again I thank you for this opportunity to present this submission. I am also pleased to make myself available to answer any questions and if it would assist you further I can be available to present a visual power point understanding of the professional services private practice midwives provide.



Appendix 1

Professional Synopsis

47 years of health professional service, education, practice and experience

My career began with a very satisfying nursing experience, later being 'a patient' on the receiving end of the health system I realized just how important quality personalised professional care was to health recovery. After 10 years of full time mothering an inner desire guided me back to professional life. An extended career emerged amidst a range of professional and educational experiences; my chosen career path Midwifery has spanned 35 years to date.

Fortunately I received excellent advice and support from senior colleagues; valuable in guiding me on a pathway to a committed career to finally establishing my private midwifery practice. My journey has not been overly planned, instinctive by nature I am intuitively guided in career pathways and the life cycle so far.

From the beginning I have been involved in professional development, education, practice, mentoring, submission writing and publications. I have provided expert opinion for lawyers and appeared as an expert witness in several midwifery/medical cases. I have also participated in movie making for nursing and midwifery education, written and had letters published in the media, and almost every day, like one of my mentors UK midwife Caroline Flint, I proudly promote the profession of midwifery by telling someone about the role of the midwife. I have presented my educational DVD publications *The Energy of Water in Labour & Birth* and *Neurological Breastfeeding* at local, national and international conferences, all evidenced in my extensive Curriculum Vitae. I continue the pursuit of a long standing professional commitment to regain access to Professional Indemnity Insurance for Midwives. Most recently I have written a section for the book *With Woman*, A Collection of Midwives' Stories edited by David Vernon and published by the Australian College of Midwives (ACM), sharing my experiences moving from shift work to private practice. I am currently a Director on the Board of the ACM and have completed a Midwifery Practice Review (MPR), September 2007. March 2008 I commenced a full-time Masters by research at Charles Darwin University, NT this was converted to a PhD, March 2009.

Career highlights

My career path over the past 48 years includes qualifications and experience in Midwifery, General and Maternal & Child Health Nursing, Family Planning, Breastfeeding/Lactation Consultancy; a Bachelor of Applied Science in Advanced Nursing and completion of re-entry into Family, Child and Community Health nursing (Deakin University).

Private midwifery practice, Melbourne Midwifery Pty Ltd (MMSS), commenced in 1986, established as a company in 1987. MMSS provides personalised care for women from pre-pregnancy, through the entire maternity continuum to early parenting.

For eight years 2001-2009, I provided part time In-Home Breastfeeding services for women living in the Darebin precinct, Melbourne. Women experiencing breastfeeding complications were referred by Darebin Maternal & Child Health Nurses out of nine centres. This practice commenced my research. Simultaneously, I continued my private birthing and breastfeeding practice. Debriefing is paramount for women experiencing breastfeeding difficulties. Most women reflect on the impact of technocratic birthing practices; questionable separation from their babies; delayed breastfeeding; assisted forceful breastfeeding techniques; early introduction of animal milk products using an array of feeding devices. Other important factors identified in the research were feelings of confusion particularly associated with the levels of conflicting advice, feelings of fear inhibiting innate maternal wisdom, interruption to newborn neurological survival skills, neonatal digestive difficulties, unsettled-crying babies, excessive newborn weight loss and maternal exhaustion affecting the initiation and duration of breastfeeding.

International/National Presentations

- Hong Kong Midwives Association, Seminar for Midwives: *The Visual Energy of Water in Labour & Birth plus Neurological Breastfeeding at Queen Elizabeth Hospital, Hong Kong, October 5 2005*

- "A Labour of Love?" - Emotion Work and Reproduction Conference, at the Huddersfield University, London, UK. *The Visual Energy of Water in Labour & Birth,* September 16 2005

- Australian Association of Maternal, Child and Family Health Nurses, Inaugural National Conference, Melbourne. "Coming Together Nationally". *Neurological Breastfeeding – Evidence from the Darebin Database* April 28-30 2005

Audio Visual Productions

2005 *Neurological Breastfeeding- Distortion the cause of Nipple Damage*

2004 *The Energy of Water in Labour & Birth*. DVD Presentation to music

1998 *Melbourne Midwifery* Website http://www.melbmidwifery.com.au

1997 *Birthing Naturally – With an Australian Family*. Melbourne Midwifery Pty Ltd. Video production. The Birth of four Martin Family babies

1991 Monash University Frankston – Interview: *Professional Issues and Community*
Sep *Practice for the Future*

1990 Women in Business – Video Production of a Presentation: *Setting up a Business*
Nov *in Victoria* Council of Adult Education – Interview: *Private Midwifery Practice*
Oct Affirm – Psychological Consultancy

Jun Australian Nursing Federation – Actor in Video Production: *Sitting Down with Mrs Marshall.* Banksia Video Productions: Videotapes as an adjunct to nursing education

1988 Preparation of Video Script – *"Bathing a Baby".* Narrator, Bernadette Kean.
Sep Produced by Deakin University, Victoria

Research

2009 Mar Conversion to PhD, Charles Darwin University

2008 Mar Masters by Research, Charles Darwin University

2001- Darebin Maternal & Child Health Service – In Home Breastfeeding Service – Data

2008 collection, analysis and reporting.

1988 Participant in a World Health Organistion – Pilot Multicentre Study of the duration of Lactational Amenorrhoea in relation to Breastfeeding Practices

Appendix 11

For privacy reasons identifying information has been removed for the following email received July 14th

From: I.....S.....
Sent: Tuesday, 14 July 2009 5:06 PM
To: midwife@bigpond.net.au
Subject: General Enquiries

Dear Robyn,

I came across your website a few months ago, but up until now have not had the opportunity (or need) to contact you - but I can happily say that I now do!

My name is ....., and I am currently expecting my second little one with my husband..... My first (.....) is now 25 months, and my second is due around the 15th of March 2010. I know that it is still early days yet, but I would rather have all my birthing plans etc. in place earlier rather than later, this time around. We currently live in ....., but we'll hopefully be in ..... (where we are currently building) by Feb' or early March '10. Do you service these areas?

Before I continue, I should probably tell you a little about my past pregnancy history:

My pregnancy with .....was OK, but as I did not know very much about pregnancy or proper prenatal medical care at the time, I failed to ever have a proper physical exam during my pregnancy, or even get into contact with an OB or midwife (as I was told by my GP at the time, that it was unnecessary to contact either one until "much later" into the pregnancy, or unless I were to have any problems). Due to the lack of medical care, it went unnoticed that I had an incompetent cervix until I went into premature labour one evening at 24 weeks. Luckily, we currently only live 5 minutes away from .....Hospital, where they were able to stop the contractions (even though I was 7 cm dilated). I was assigned to hospital bed-rest for the next few weeks, until going back into labour and giving birth at 29 weeks (due to an ever increasing infection that I had contracted from to my cervix remaining dilated for so many weeks).

From this experience, I am naturally far more cautious now in regards to this pregnancy, and will certainly be taking every precaution to ensure a safe gestation & birth. But also due to my bad(ish) hospital experience, I am very reluctant to give birth in a hospital again (which is why I am contacting you).

According to estimates given to be this morning by a .....radiologist & obstetrician, I am around the 5 week mark in my pregnancy, and according to an ultrasound & blood sample taken this morning, everything is as it should be, and everything is 'looking good'. I will be going back there in 2 weeks, for a further ultrasound, blood analysis and referral to a cervical clinic, who will then be able to assist me further (in regards to having a cervical stitch put in place, as well as ongoing monitoring - should all go as planned).

Firstly, is it even still viable for me to hope for a home (water)birth, considering my past pregnancy history?

If so, what would be the next steps to take? What are your payments terms?

Thank you very much for your time in advance, and for your response.

Hoping to hear from you soon,

Appendix 3

Definition of a Midwife

http://www.midwives.org.au/

A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

Adopted by the ACM19th July 2005
Supersedes the ICM the International Definition of the Midwife 1972 and its amendments of 1990.

Robyn Thompson

RM, RN, M&CHN, BachAppSc, BF Cons

PhD Student

Charles Darwin University NT

www.melbmidwifery.com.au

midwife@bigpond.net.au

Mob: 0418 324 058

In summary ACM strongly urges health ministers to make the following changes to the draft bill in the interests of public protection:

1. Ensure that private midwives providing care for women wishing to birth at home have access to professional indemnity insurance by 30 June 2010 **OR** include a temporary exemption clause for health professionals who are unable to gain access to professional indemnity insurance from an APRA regulated provider until such time as such PI becomes available
2. Discard the concept of a 'Midwife Practitioner' and refer to 'midwife'
3. Ensure three midwifery positions, not one as is currently suggested, on the National Board
4. Include one representative from each participating State and Territory on the National Board
5. Protect the practice of assisting a woman in birth

Research evidence confirms that birth at home is a safe option for women at low risk of complication attended by a competent midwife (de Jong et al 2009, Bastian et al 1998, Davis et al 2005, Olsen 1997, Symon et al 2009, Wiegers et al 1995). It is essential that women who choose to give birth at home continue to have access to a regulated, competent, and up-to-date midwife. Already there are grave concerns that women are birthing without the skilled attendance of a midwife it is anticipated that if midwives are prevented from attending labouring women at home from 1 July 2010, more women will choose to give birth unattended. In this scenario it is inevitable that preventable deaths of both mothers and babies may occur. Who will take responsibility for this if decisions are made that prevent women and midwives working together in the home?

There are many reasons why women choose to have the full scope of midwifery and some medical service at home. Some women choose homebirth for religious or cultural reasons. Others choose homebirth because they feel safer at home in the care of a known midwife or midwives, than with multiple midwives and doctors who are unknown to them in a maternity hospital . Others feel secure not being coerced into the technological and interventionist environment. Some women choose homebirth because they find that hospital services do not offer evidence based care if they wish, for example, to give birth vaginally after a previous caesarean section.

There must be a sensible Australian recognition and a supportive outcome for removing irresponsible denial of the rights of women to birth at home with the best possible midwife care available.

The Australian College of Midwives is the professional body representing midwives across Australia.

We provide this submission to provide further information supporting the position presented in the APNMF submission for resolution to the lack of access for existing private midwives to professional indemnity insurance to enable compliance with s69 and s101(a)ii of the Exposure Bill B. We are a signatory to that submission as a member of the APNMF.

Indemnity Insurance

ACM supports the position that all health professionals should hold professional indemnity insurance as a safety net for consumers. We know that health ministers are already aware that midwives in private practice are not currently able to access professional indemnity insurance. The federal government's move to legislate for a scheme to support Medicare eligible midwives to access affordable professional indemnity insurance is most welcome. However, as you would be aware, the Commonwealth scheme will not include cover for a midwife providing care to a woman labouring and giving birth at home.

In the absence of a solution being found to the lack of indemnity for midwives providing care for homebirth, we fear that safety for women choosing to give birth at home will be compromised from 1 July 2010. Publicly funded homebirth services are not widely available in Australia. Where they are available, they tend to be located in specific geographic locations with limited access.

Research evidence confirms that birth at home is a safe option for women at low risk of complication attended by a competent midwife (de Jong et al 2009, Bastian et al 1998, Davis et al 2005, Olsen 1997, Symon et al 2009, Wiegers et al 1995) It is essential that women who choose to give birth at home continue to have access to a regulated, competent, and up-to-date midwife. We have grave concerns that if midwives are prevented from attending labouring women at home from 1 July 2010, some women will choose to give birth unattended. In such a scenario it is inevitable that preventable deaths of both mothers and babies may occur.

Some women choose homebirth for religious or cultural reasons. Others choose homebirth because they feel safer at home in the care of a known midwife or midwives, than with multiple midwives and doctors who are unknown to them in a maternity hospital. Some women choose homebirth because they find that hospital services do not offer evidence based care if they wish, for example, to give birth vaginally after a previous caesarean section.

ACM believes there is potential for this challenging policy issue to stimulate improvements in care for women who choose homebirth. We are working on a professional framework for homebirth that is intended to provide transparent guidance to

women, midwives and other health professionals involved in caring for women who, for whatever reason, make an informed decision to plan homebirth. The ACM intends to consult with state and territory governments and with professional and consumer stakeholders on this document in coming months. w.

Comment [R1]: We say above homebirth is safe, no need to enhance?

Whether making private homebirth midwifery effectively unlawful is an unintended consequence of the NRAS scheme or a deliberate policy by health ministers (if the latter this should be declared), women will continue to exercise their right to choice about their bodies and the birth of their babies. It is imperative that women's access to competent professional care through the NRAS scheme is enhanced rather than restricting access.

In the interests of public safety, ACM urges health ministers to either:

1. include a temporary exemption clause for health professional unable to gain access to professional indemnity insurance from an APRA regulated provider until such time as such PI becomes available for homebirth midwifery care, or
2. Ensure that private midwives providing care for women wishing to birth at home have access to professional indemnity insurance by 30 June 2010.

Midwife Practitioner

The endorsement of a midwife practitioner s113 is contrary to the clearly articulated position of the profession (Australian College of Midwives 2005). The profession defines a midwife's scope of practice in accordance with the ICM definition of a midwife (International Confederation of Midwives 2005) as working with women across the childbirth continuum. Midwives who provide care across all areas of the childbirth continuum to the full scope of midwifery practice (i.e. providing care in their own right for the full episode of care consulting and referring as required) must not be re-defined as a "midwife practitioner". The scope of practice for midwives is consistent from initial regulation throughout the career of a midwife.

Definition of speciality in a specific area of midwifery practice is contrary to the definition of a midwife but is consistent with the current framework for "nurse" practitioners. It is therefore the position of the profession that midwives working as specialists in a particular area of practice (i.e. fetal medicine, ultrasonography, women's health) would be more appropriately endorsed as "nurse practitioner – midwife". The pathway to "nurse practitioner" endorsement (Masters qualification plus specific experience) is not appropriate for midwifery where initial qualification for practice may be at Masters level.

Comment [R2]: Maybe ultrasonography but not lactation - it is a part of midwife/mother postnatal care.

Comment [R3]: Needs to be more clear

There is further concern amongst the profession that the midwife practitioner endorsement may be used for Medicare eligibility. The ACM welcomes the announcement in the May Budget that Nurse Practitioners would also be granted MBS and PBS access. This commitment will be significant in enhancing access for consumers to the expertise of Nurse Practitioners. We strongly believe it will not be financially viable, workable or sensible to apply the same methodology for identifying highly experienced midwives who are to be eligible for Medicare and PBS funding for their care for a number of reasons:

Comment [R4]: Can this be added?

1. Masters degrees in midwifery are often entry to practice courses not advanced practice courses

Comment [R5]: Can this be clearer/stronger?

Nurse Practitioners undertake a Masters Degree course as part of qualifying for Nurse Practitioner status. In midwifery, many universities offer Masters of Midwifery degrees not as an advanced practice qualification for registered midwives, but as an entry to midwifery practice qualification for registered nurses. This means that use of the Masters qualification to identify eligible midwives would potentially capture newly qualified midwives.

Comment [R6]: Needs to be clearer to the reader

It is further the case that Masters programs undertaken by Registered Midwives are unlikely to provide assurance of the knowledge and skills we will need Medicare eligible midwives to have. Research masters programs undertaken by Registered Midwives usually facilitate expertise in researching a particular aspect of midwifery or maternity care. Such programs are valuable in adding to the research base for provision of midwifery and maternity care but do not aim to enhance the clinical knowledge and skills of the student across the full scope of midwifery practice.

Comment [R7]: Need to change we to ACM not strong enough

In short, relying upon a Masters qualification will be a poor predictor of suitability of a midwife to provide Medicare funded care to women in the community across pregnancy, labour and birth, and postnatally. It is essential instead, that the requirement for midwives is to have a suitable entry to practice qualification, and to provide evidence of current clinical competence across the full scope of midwifery practice.

2. Continuity of midwifery care includes a level of professional expertise, robust knowledge and skill across the full scope of midwife practice, not specialised knowledge in only one area.

Nursing covers a broad range of skills, knowledge and competence relevant to all areas of nursing, health and aged care. Nurse Practitioners develop specific expertise in a chosen area of healthcare (e.g. drug and alcohol dependence, reproductive health, mental health, aged care). It is understandable that Masters level study helps nurses to develop specialised expertise in their chosen field ahead of applying to become a Nurse Practitioner.

Midwifery, by contrast, has a well defined and constant scope of practice. Whether a midwife is a new graduate or has 20 years experience, and whether she is employed or self employed, her scope of practice stays the same – the provision of care to women during pregnancy, labour and birth, and postnatally. This scope is internationally defined and codified in Australian regulation of the profession, within the ANMC's Competency Standards for the Midwife.

3. Type of experience a better indicator than length of experience

Eligibility for Nurse Practitioner currently varies across Australia. Each state regulatory Board has developed its own criteria for endorsing Registered Nurses as Nurse Practitioners. In some states, RNs require 5-6 years of clinical practice experience as well as a Masters qualification before being eligible to become a Nurse Practitioner.

For midwifery, the length of time that a midwife has been practising is likely to be less of an indicator of the experience and knowledge we need Medicare midwives to have than the type of experience they have. As the research evidence on the benefits of midwifery care clearly shows, it is the continuity of care by a known midwife that delivers measurable benefits to mothers and babies.

We propose that successful credentialing with the ACM Midwifery Practice Review (MPR) Program is the most appropriate mechanism to ensure that midwives possess and maintain knowledge and skills relevant to the care of women and babies across the maternity care episode with Medicare funding. We suggest that the appropriate title for midwives who are "eligible" for MBS/PBS access is "midwife – MBS eligible". This title may be an endorsement considered under this legislation or it may be an endorsement set down in regulation.

Protection of Practice

No protection exists under Exposure Bill B of the practice of assisting a woman in birth. The ACM recognises that recent changes in some jurisdictions (e.g. South Australia) have resulted in a move away from protection of practice. This is a retrograde step in protection of public safety particularly when combined with the effective de-regulation of care for women who birth at home. The issue regarding indemnity insurance has been discussed earlier in this submission. The impact of a lack of protection of the practice of assisting a woman in birth and an inability for women to access a registered midwife for birth mean that it will not be an offense for unregulated practitioners (using any title other than midwife – currently often 'birth worker' is used) to attend a woman in birth. It is possible for this to be the easiest pathway for those wanting to continue to provide care for women in home birth and a lack of protection of this practice under legislation means that there is nothing to prevent this from occurring.

Comment [R8]: Can we do a flow chart that helps the reader follow? Maybe or maybe not appropriate, just asking.

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