Eastside Midwives

10th December 2009

Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
Canberra
ACT 2600

Email: community.affairs.sen@aph.gov.au

Dear Mr Humphrey

Thank you for the opportunity to provide a submission to the Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills.

Eastside Midwives is a private midwifery group practice located in the outer eastern suburbs of Melbourne, offering continuity with a known midwife for women and their families planning home or hospital births. We ask the Senate Standing Committee on Community Affairs to do all in its power to block the passage of the amendment to the midwifery bills mandating collaborative arrangements.

In undertaking this Inquiry we ask the Committee to consider:

a) that the consequences of the Government's amendments WILL give doctors medical veto over midwives' ability to renew their licence to practice

It appears that the collaborative requirement is 'one-sided', in that private midwives will be required to provide evidence of collaboration in order to access professional indemnity insurance and subsequent registration, in order to be able to practice. There is however, no mandated requirement for doctors and hospitals to collaborate with private midwives.

It has been the experience of Eastside Midwives that many GPs and obstetricians have refused our requests for prescriptions for emergency oxytocic drugs and anti-D, and pathology request slips for antenatal and postnatal blood tests. We have also attempted to secure back-up booking arrangements in the event that an emergency transfer becomes necessary. We have met with a number of doctors who have admitting rights to our local hospital but they have refused to be involved with women planning homebirths. The hospital will also not allow the women or midwives to make the back-up booking themselves.

RANZCOG, NASOG and the AMA are openly opposed to homebirth in their policies and media statements (1, 2). Should the collaborative requirement become mandatory we have no doubt that members of these organisations will be actively discouraged from collaborating with the private midwives providing homebirth services for women.

Private midwives providing homebirth services in Victoria have always sought collaborative arrangements and arranged for consultation and referral when required. Our maternal & newborn outcomes as reported on by the Perinatal Data Collection Unit (Vic) each year are evidence of the safe care we already provide. Mandating collaborative arrangements however, effectively gives doctors the power to decide which midwives (if any) are eligible to gain insurance and register. This is completely unacceptable. No other health profession is at the mercy of another for its registration and right to practice.

b) that the Government's amendments' influence on the health care market WILL be anti-competitive

Private obstetricians are already extremely well supported in the health care market (healthy pregnant women) through Medicare funding and the safety net, private health insurance rebates, subsidised

professional indemnity insurance and hospital access rights, compared with their current 'competitors', midwives in private practice. This monopoly situation would be further enforced with the proposed amendments which would effectively give doctors the power to restrict midwives from registering and providing the same service.

We draw your attention to following statement in the *Medical Observer*, Friday 6th November 2009:

"The amendments to the nurse practitioner [midwife] legislation will come as welcome relief for doctors, who feared that without mandated collaborative arrangements in place nurse practitioners [midwives] would work independently…AMA vice-president Dr Steve Hambleton, who sits on the Government's Nurse Practitioner Advisory Group (NPAG), said ***the crucial amendment would ensure nurse practitioners [midwives] were not supported to work in competition with doctors****."*

Access to professional indemnity insurance and the midwife's right to provide care for healthy pregnant women can NOT be determined by doctors who have a vested interest in seeing private midwives and homebirth obsolete.

c) that the Government's amendments WILL create difficulties in delivering intended access and choice for Australian women

Private midwives are currently the only registered midwives in Victoria who offer a homebirth service and we cover the entire metropolitan area and a large portion of the regional and rural areas.

If we are unable to register and practice, women will no longer have the choice of birth at home with a private registered midwife available to them. There is a plan to commence two hospital run homebirth programs in the future but they simply will not be able to meet the needs of all women choosing homebirth in terms of living distance from the two hospitals and the restrictive hospital policies on eligibility for homebirth.

d) that the Government's amendments WILL have a negative impact on safety and continuity of care for Australian mothers

True continuity of midwifery care is extremely difficult for women to access outside of a private midwifery practice.

We have been told by women that if they are unable to have a registered midwife attend their planned homebirth next year, they will "freebirth" – that is, they will give birth unattended or with an unregistered helper. While some women currently choose this as an option, we find it completely unacceptable that other women are potentially being forced into this situation because the midwives they would choose to care for them will be unable to register.

The safety of mothers and babies **will** be compromised when the current transparent processes for consultation, referral and transfer of care, which are **already** standard professional midwifery practice, are no longer in use.

Yours sincerely

Andrea Bilcliff

(On behalf of)

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Attachments: 1- NASOG Media Release, 2 - RANZCOG Statement on Homebirth

National Association of
Specialist Obstetricians & Gynaecologists

Media Release Tuesday August 18 2009

Please Put the Safety of Babies and their Mothers Ahead of Home Birth Ideology: Specialist Doctors

Australia's peak group of obstetricians and gynaecologists today repeated its warning that home births – with or without a midwife – carry too much risk to babies and their mothers and the Government should resist calls to indemnify midwives outside of hospitals.

The President of the National Association of Specialist Obstetricians and Gynaecologists (NASOG), Dr Hilary Joyce, congratulated the Government-majority Senate Committee investigating proposed legislation relating to the role of midwives, for putting the safety of babies ahead of protestations by a small but vocal minority of people.

"I would urge all politicians to look to the evidence and to speak to the doctors and the midwives who have to deal with some of the tragic consequences of home births," Dr Joyce said today.

"Australia has one of the safest and highest quality maternity services in the world where specialist doctors work side by side with qualified midwives to ensure babies and their mothers have a safe and successful birth experience."

Dr Joyce said she was determined to help drive change in the way public and private hospitals present their maternity services to encourage all expectant mothers to opt for a safe and positive outcome under the care of specialist doctors and midwives working together.

"There is irrefutable evidence that women and babies are significantly safer in hospitals because of the immediate access to specialist care. Thankfully, only 0.25% of Australian women risk their lives and that of their babies by choosing a home birth."

Dr Joyce said the Minister for Health and Ageing was acting in the best interests of babies and their mothers by refusing to financially endorse the unsafe practice of delivering babies at home.

"There are things that can go wrong suddenly in a birth which, if not under specialist care or near medical assistance, can result in an avoidable death or permanent injury," Dr Joyce explained.

Dr Joyce said rather than call for the Government to fund insurance for an unsafe practice, politicians and health professionals should ask for funding to be directed to educating women and their families about the risks of home births."

Dr Joyce said her organisation would continue to work closely with the Federal Government to deliver the optimal collaborative model of obstetric care to all Australian women.

For all media inquiries, please contact:

Dr Hilary Joyce
President of NASOG 0418 600 858 or 02 48 624004
*NB: Dr Hilary may be treating patients so may not be able to answer directly

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About NASOG: The **National Association of Specialist Obstetricians and Gynaecologists** (NASOG) is a not for profit professional association representing specialist obstetricians and gynaecologists, the leading providers of specialist women's health services. Australia is recognised as one of the safest countries in the world to give birth or to be born. **NASOG** strongly endorses our **collaborative, proactive model of obstetric and midwifery care** for all women giving birth in Australia. The safety of this existing model of care is confirmed by research from Australia and around the world. www.nasog.com.au

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College Statement

Title	**Home Birth**
Statement No.	**C-Obs 2**
Date of this document	**August 2009**
First endorsed by Council	**March 1987**
Next review due:	**November 2011**

Statement

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) does not endorse Home Birth.

In Australia about 0.2% of women deliver their babies at home. However this may be an underestimate, as it is unlikely that all babies born at home are recorded in perinatal data collection statistics.

Whilst mindful of a women's right to personal autonomy and decision making, RANZCOG cannot support the practice of Home Birth due to its inherent risks and the ready availability of safer birthing practices. Where a woman chooses to pursue Home Birth, it is important that this is an *informed* choice, considering all the benefits and possible adverse outcomes.

1. Perinatal and Maternal Outcomes

1.1. Perinatal Mortality

Whilst collection of accurate and reliable data from planned Home Birth is notoriously difficult (Mori et al, 2008; Gyte et al, 2009), it is likely that planned Home Birth is associated with poorer outcomes for both mother and baby (Bastian et al, 1998). Recent concerning data from Western Australia evidenced a higher perinatal mortality for planned Home Birth at term. For those planning a hospital birth the perinatal mortality for the years 2000–2006 was 2.22 per 1,000 births whilst that of planned Home Birth was 7.96 per 1,000 births. This 3-4 fold increase in perinatal

mortality was statistically significant (OR 3.58; 95% CI 1.8-6.9; p<0.001)(Western Australian PIMC 12th Report, 2007).

In response to the concern regarding increased perinatal mortality apparent in women planning Home Birth, an inquiry into Home Birth was undertaken at the request of the West Australian government. The two investigators focussed on the need for accurate data collection and improvements in service provision (Homer & Nichol, 2009). Of particular concern was the apparent inappropriate selection of patients for Home Birth, as there is evidence that the perinatal mortality associated with care by an independent midwife can, at least in part, be ascribed to poor screening of women by the independent midwife (Symon et al, 2009). In that study there was similarly a 3.5-fold increase in perinatal mortality amongst those women booked under an independent midwife compared to conventional care.

The quantification of Home Birth outcomes requires sophistication of data collection that is difficult to accomplish. Perinatal data must be referable to 'place of intended birth' rather than identification of the outcome by the 'actual place of birth'. Classification by the latter is particularly misleading as intended Home Births transferred to hospital as complications arise will be recorded as a hospital birth, whilst otherwise uncomplicated but precipitate births occurring at home will be recorded as Home Births, even though the intention was to deliver in hospital.

1.2. Maternal Satisfaction

In those selecting Home Birth, it is likely that maternal satisfaction would be greater than birthing in hospital– providing serious adverse outcomes do not occur. Although the numbers required to assess maternal satisfaction would be relatively small, quality statistical data is largely lacking.

2. Alternatives to Home Birth

2.1. Collaborative Model of Care

Collaborative care between midwives and obstetricians (specialist or GP) in a hospital setting is considered the best model of maternity care. This model provides the opportunity for close surveillance of mother and baby during labour and the implementation of appropriate and timely interventions if problems arise. In the absence of complications, minimal intervention is required.

2.2. Alternative Birth Centres and Low Intervention Models of Care

It seems likely that birth in a 'home-like' setting with close proximity to hospital care can achieve some of the aesthetic appeal of Home Birth but with reduced exposure to risk. Even so, a review of the relevant clinical trials reveals a strong trend towards higher perinatal mortality with hospital birth in a home-like setting. An overview of the perinatal mortality in five trials (n = 8529) showed a relative risk of perinatal death of 1.83 (95% CI 0.99 to 3.38) when compared with conventional hospital birth (Hodnett et al, 2005).

De Jonge et al (2009) found no difference between "midwife-led care in hospital" when compared to "midwife-led care at home, with respect to "intrapartum perinatal mortality" in the Netherlands. It therefore appears likely that aspects of "midwife-led care" (e.g. lower levels of fetal surveillance and reduced levels of obstetric intervention) contribute to the higher perinatal mortality of Home Birth at term. The higher perinatal mortality in the Netherlands relative to other Western countries

has received attention in the literature (Mohangoo, 2008). Whilst the reasons are undoubtedly complex and it would be inappropriate to attribute this entirely to Home Birth, maternity care in the Netherlands has a tradition of “low intervention” (Keirse, 2009).

3. Homebirth for Australia and New Zealand?

3.1. Why should Australia have lower frequencies of Home-Birth?

Australia is a geographically diverse country and has a poorly developed infrastructure for Home Births. The geography does not suit itself to obstetric “flying squads” that are readily available to retrieve mothers from home when problems have arisen during labour and birth. Australia has the dual problems of vast distances in rural settings, and heavy city traffic in Melbourne and Sydney. Evidence is that approximately 12 to 43% of those identified as “low risk” in pregnancy will develop a complication necessitating transfer to care in a conventional birth suite setting (Mori et al, 2008; Stern et al, 1992). In many locations in Australia this cannot be accomplished expeditiously.

3.2. New Zealand

Although Home Birth is more common and more accepted in some areas of NZ, there are no robust, published data that prove that Home Birth is as safe as hospital birth. The “tyranny of distance” from remote and rural settings combined with an absence of “obstetric flying squads”, applies as much in New Zealand as in Australia.

4. Resource Utilisation

Home birth caters for only a relatively few women. It is resource intensive and those resources may be better utilised elsewhere.

5. Informed Choice?

A decision to give birth at home must be taken in the knowledge that there are relatively few resources available for the management of sudden unexpected complications that may affect *any* pregnancy or birth – even those without any acknowledged obstetric risk factors. These include most commonly acute fetal compromise (e.g. from cord compression in the second stage of labour) and postpartum haemorrhage. Women contemplating Home Birth need accurate information about these risks.

6. Minimal Standards for Home Birth

RANZCOG is aware of differing attitudes in the community regarding pregnancy and its management and accepts that the aspirations of parents vary considerably. Recognising that a small number of women have chosen, and will continue to choose, a domiciliary environment in which to give birth to their babies, the College makes the following recommendations:

a. Women seeking Home Birth should be

i. Informed regarding the increased risks of Home Birth in comparison to hospital birth for women and their babies, as demonstrated by available evidence
ii. Counselled regarding the significance of these risks as applied to their own obstetric condition
iii. Urged to consider giving birth in a suitable hospital environment such as a Birthing Centre.

b. Women choosing Home Birth should be cared for by both an experienced medical practitioner and a registered midwife, each of whom has agreed to participate.

c. It is recommended that women considering Home Birth should seek information from their Home Birth providers about the providers' experience in Home Birth, their training, experience and skills in the management of maternal and neonatal emergencies which may occur unexpectedly in the home. They also should be informed of the contingency plan in the event of an emergency including options for hospital transfer and pre-existing arrangements that are in place for transfer of care to an appropriate health care provider qualified to manage the complication(s) necessitating transfer from the home environs.

d. The women and her baby must be cared for by health professionals with indemnity insurance:
    i. Insurance should be sufficient to cover adverse maternal or fetal outcomes
    ii. Premiums must reflect the greater risk associated with provision of Home Birth care
    iii. Details of indemnity cover should be transparent and declared to the patient

e. All women booked for Home Birth should be recorded by the relevant Health Authority. The Health Authority and care provider must ensure adequate and compulsory documentation so that meaningful data can be obtained for quality assurance at both a local and national level.

f. Health professionals caring for women having Home Birth have an obligation to ensure a system for immediate transfer to an obstetric hospital in the event of an emergency.

g. Individuals conducting Home Birth have the same responsibility as other maternity carers to engage in multidisciplinary peer review and audit of practice.

7. Should Home Birth be offered as a "Model of Care"?

Home Birth should not be offered as a "Model of Care".

It is clear that for the majority of women, the actual margin of safety they desire in giving birth is in fact very high (Walker et al, 2007). Provision of a 'Home Birth' service would falsely provide *de facto* evidence of an acceptable margin of safety for both mother and child that is not based in scientific evidence. However, it is acknowledged that there is a very small minority of women, who are prepared to assume substantial personal and fetal risk as a consequence of prioritising their birth experience (Walker et al, 2007).

8. Summary

a. Home Birth is not endorsed as it is associated with an unacceptably high rate of adverse outcomes.

b. Home Birth should not be offered as a model of care as there is a reasonable public expectation that any model of care that is offered has a margin of safety that would be acceptable to most women. This is not present in the setting of Home Birth

c. Women contemplating Home Birth must be provided with accurate information about the risks involved

d. Home Birth will remain in demand by a small number of women who choose to prioritise this aspect of their birth experience above that of risk minimisation.

e. Women choosing Home Birth should be cared for by both an experienced medical practitioner and a registered midwife, each of whom has agreed to participate.

f. Health professionals supervising Home Birth should have appropriate indemnity insurance. Indemnity insurance premiums must reflect the associated increased risks

g. Women considering Home Birth should seek information from their Home Birth provider about the provider's experience in Home Birth and their contingency plan in the event of an emergency including options for hospital transfer.

h. All women booked for Home Birth should be recorded by the relevant Health Authority. The Health Authority and care provider must ensure adequate and compulsory documentation so that meaningful data can be obtained for quality assurance at both a local and national level.

i. Health professionals caring for women having Home Birth have an obligation to ensure a system for immediate transfer to an obstetric hospital in the event of an emergency.

j. Individuals conducting Home Birth have the same responsibility as other maternity carers to engage in multidisciplinary peer review and audit of practice.

References

1. Bastian H. Keirse MJ, Lancaster PA. Perinatal death associated with planned Home Birth in Australia: population based study. BMJ. 1998 Aug 8;317 (7155):384-8.
2. Bloomfield L. Homebirths—is this a suitable matter of legislation? Australia Nurses J. 1981 Nov;10 (11):23-4.
3. Crotty M, Ramsay AT, Smart R, Chan A. Planned homebirths in South Australia 1976-1987. Med J Aust. 1990 Dec3-17;153 (11-12):664-71.
4. de Jonge A, van der Goes BY, Ravelli AC, Amelink-Verburg MP, Mol BW, Nijhuis JG, Bennebroek Gravenhorst J, Buitendijk SE. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. BJOG. 2009 Aug;116(9):1177-84.

5. Gyte G, Dodwell M, Newburn M, Sandall J, Macfarlane A, Bewley S. Estimating intrapartum-related perinatal mortality rates for booked home births: when the 'best' available data are not good enough. BJOG. 2009 Jun;116(7):933-42.
6. Hodnett ED, Downe S, Edwards N, Walsh D. Home-like versus conventional institutional settings for birth. *Cochrane Database of Systematic Reviews* 2005, Issue 1. Art. No.: CD000012. DOI: 10.1002/14651858.CD000012.pub2.
7. Homer C, Nicholl M. Review of homebirths in Western Australia. Undertaken for the Department of Health WA. August 2008.
8. Howe KA. Home births in south-west Australia. Med J Aust. 1988 Sep 19;149 (6):296-7, 300, 302.
9. Janssen P, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D, Klein MC. Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. Canadian Medical Association Journal (CMAJ) 2002;166(3):315 – 323.
10. Johnson KC, Daviss B-A. Outcomes of planned home births with certified professional midwives: large prospective study in North America. BMJ June 2005;330;1416-
11. Keirse MJNC. Perinatal mortality in the Netherlands (BMJ Editorial). BMJ 2009;338: b1491
12. Mohangoo AD, Buitendijk SE, Hukkelhoven CW, Ravelli AC, Rijninks-van Driel GC, Tamminga P, Nijhuis JG. Higher perinatal mortality in The Netherlands than in other European countries: the Peristat-II study. Ned Tijdschr Geneeskd. 2008 Dec 13;152(50):2718-27.
13. Mori R, Dougherty M, Whittle M. An estimation of intrapartum-related perinatal mortality rates for booked home births in England and Wales between 1994 and 2003. BJOG 2008; 115: 554-559
14. Stern C, Permezel M, Petterson C, Lawson J, Eggers T, Kloss M. The Royal Women's Hospital Family Birth Centre: the first 10 years reviewed. Aust N Z J Obstet Gynaecol. 1992 Nov;32(4):291-6.
15. Sullivan P. Perinatal death associated with planned home birth in Australia. Home births are not justified in Australia. BMJ. 1999 Feb 27;318 (7183):605-6.
16. Symon A, Winter C, Inkster M, Donnan PT. Outcomes for births booked under an independent midwife and births in NHS maternity units: matched comparison study. BMJ 2009; 338:b2060
17. Walker SP, McCarthy EA, Ugoni A, Lee A, Lim S, Permezel M. Cesarean delivery or vaginal birth: a survey of patient and clinician thresholds. Obstet Gynecol. 2007 Jan;109(1):67-72.
18. Western Australia. 12th Report of the Perinatal and Infant Mortality Committee of Western Australia, 2007

Links to other related College Statements

Nil

Disclaimer:

This college statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

This College statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that College statements are accurate and current at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the date of the statements.