Australia's national maternity consumer advocacy organisation

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Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee
PO Box 6100
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Dear Senator Moore

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

Maternity Coalition Victoria (MCVic) strongly endorses the submission prepared on behalf of the National Committee of Maternity Coalition. We agree that the amendments announced on 5 November 2009 should be withdrawn and that midwives should not be required to enter into prospective collaborative arrangements with medical professionals in order to be eligible for insurance and Medicare funding.

The purpose of this submission is to complement the national submission by presenting the experiences of Victorian women. The submission provides some detail about the options that are currently available for women in Victoria to have continuity of care. It then looks at some examples of how women currently experience collaboration between midwives and medical practitioners in Victoria and what this might mean for formal requirements to collaborate.

The women whose names have been used in this submission (with their permission) have in most cases also made their own submissions to the Senate Inquiry and their complete stories can be found in those submissions.

Continuity of care in Victoria

There are limited options available in Victoria for women who want to have a known caregiver looking after them throughout their pregnancy, birth and beyond.

In Victoria many women choose to use a private obstetrician in order to have a known caregiver throughout their pregnancies. This option allows women to see the same obstetrician for all of their antenatal care and to have that obstetrician present when their

babies are born. Obstetricians do not however provide continuous care during labour and will usually only attend for brief periods (if at all) during labour and then at the time of the birth. The majority of the care during labour is provided by private hospital midwives. It is highly unlikely that the woman will have met these midwives before arriving at hospital during labour. Likewise, although the woman will probably see her obstetrician at least once in the days after the birth, she will be cared for by the hospital midwives during the immediate postnatal period. She will usually return to her obstetrician for a post-partum check-up.

Caseload midwifery is the primary means by which women in the public system can access genuine continuity of midwifery care. Caseload midwifery involves ongoing care with the same public hospital midwife for a woman's antenatal, labour, birth and postnatal care. The model is presently offered at only seven hospitals in Victoria (four rural and three metropolitan). MCVic supports this model of care and would like to see if expand further. However these programs do not (and will not in the foreseeable future) meet the needs of all Victorian women who seek continuity of midwifery care. The programs are geographically limited and are also often restricted to women who fit eligibility criteria.

In August this year the Victorian Government announced that it was establishing a pilot public home birth program at two Victorian hospitals. MCVic understands that the program is underway at Sunshine Hospital but not yet at the second hospital. MCVic again welcomes this development but notes that it is a pilot that provides continuity of care to a very small number of Victorian women who meet geographic and other eligibility criteria.

For women who want continuity of carer throughout their entire maternity care, and who do not live in the catchment area for the existing caseload midwifery or publicly funded homebirth programs, the only option is to utilise the services of a privately practicing midwife. Privately practising midwives care for women across Victoria. They work with women who plan to give birth at home and in hospital (although at present they can only act as a support person in hospital). A woman has the opportunity to develop a strong relationship with her midwife during the antenatal period and when the time comes that midwife will remain with the woman throughout her entire labour. The same midwife also visits the family daily after the birth and remains a point of contact for the family.

The stories of Erin and Helen show that this continuity of care can be the main driver for the decision to hire a private midwife.

Erin Horsley chose private midwifery care because she had suffered post traumatic stress syndrome after the birth of her first child. She needed to ensure that she would have continuous care from the one health professional who was able to take into account both her emotional and physical wellbeing during pregnancy, labour birth and the postnatal period. She consulted private obstetricians but during her discussions with them the only option offered for dealing with the issue of the PTSS was for Erin to have an elective c-section. This was not consistent with Erin's wishes. She booked into a birth centre but during her pregnancy became aware that the centre was closing down and removing midwives from the centre regularly. This did not provide Erin with the sense of security that she needed and so halfway through her pregnancy she was forced to look for another option. She chose to hire a private midwife and planned to give birth at home (with a back-up booking at a major tertiary hospital). Erin proceeded to give birth at home to a healthy baby girl. Her experience

of the care she received went beyond her expectations and she suffered no further birth related trauma.

Helen Smith gave birth to her first daughter in hospital after being transferred from a birth centre for interventions due to failure to progress after being in labour for 30 hours. When Helen came to have her second child she was very concerned about having another long labour. She needed to know that she would have continuity of care throughout the labour in order for her to be able to 'relax' into it. In hospital settings midwives are often caring for a number of different women and during a long labour a woman will often find that she is dealing with different midwives due to shift changes. Helen chose to hire a private midwife who followed her throughout her pregnancy and her second child was born at home.

MCVic strongly supports the Health Minister's goals of increasing Australian women's access to continuity of midwifery care. If the reforms are successful it is hoped that many more women will be able to access the benefits of one-to-one midwifery care. However MCVic submits that it is vital that women retain the option to directly employ a private midwife. MCVic is concerned that the amendments currently before the Senate undermine the intentions of the broader reforms and risk obstructing women's access to midwifery care.

Women's experiences of collaboration between midwives and medical practitioners in Victoria

Women who use the services of private midwives already report that their midwives consult with and refer to appropriate medical professionals when needed. Indeed consultation and referral is a key part of a midwife's professional responsibilities. What tends to differ between women's stories is whether the interaction between the professionals is a mutually respectful one. The stories below show that when genuine collaboration occurs as needed, women have high levels of satisfaction with their experience of pregnancy and birthing even if that experience does not unfold as they had originally planned. Collaboration works best when professionals respect each other's skills and perspective and when they work together to ensure that the care available to a woman is tailored to her needs and respects her individual choices.

The stories below also show that it is difficult for collaboration to work where medical practitioners do not respect the right of a woman to make informed choices about her maternity care. It also falls down when medical practitioners do not appreciate and respect the role of a woman's midwife.

Collaboration between midwives and GPs

It is widely acknowledged that general practitioners play an important primary role in women's health. For many women a visit to their GP will be their first interaction with a health professional during their pregnancies. These women often rely on the GP's advice regarding the options that are available for their maternity care. Women rarely report being told that private midwifery care is an option open to them. Women also report widely different attitudes from GPs in response to their choices to employ a private midwife for their maternity care and, in many cases, to birth at home. Under the current system midwives are unable to directly refer women for blood tests and other antenatal testing. Women wishing to access these must see a GP. The attitude of a GP can have a big impact on a woman's experience.

The following two examples show GPs who are supportive of women's choices and happy to work in a collaborative manner with midwives.

Helen Smith had a very positive relationship with her local rural GP throughout her pregnancy. The GP supported her choice to have a home birth and was willing to organise the antenatal testing that Helen wanted. The GP also respected her right to decline certain tests. The GP shared test results with Helen's midwives. Her GP also advised that she was happy to attend Helen at home in the event that she needed stitches after the birth.

At the outset of her pregnancy Isis Caple's midwife wrote a letter to her GP introducing herself and explaining the type of care that she was providing. She also set out what assistance she required from the GP in order to provide appropriate care to Isis including assistance with pathology screening and provision of scripts for medications such as syntometrine/syntocinon and local anaesthetic. Isis reports that her GP fully supported her and was positive and respectful towards her choice of pregnancy care provider.

Other women however have much less positive experiences in their interactions with GPs who are reluctant to offer care alongside a private midwife or concerned about liability and insurance issues. The following are just some of the examples that MCVic is aware of.

Cathy Stoney was called in to see her doctor at 37 weeks who told her, as a representative of the medical practice, that she should not be birthing at home given her age (40) and the amount of intervention she had had at her previous two hospital births. The doctor also stated that they would not allow Cathy to go more than a week overdue. The doctor did not present any evidence supporting what she was saying. Cathy found her manner manipulative and coercive as she presented a terrifying list of scenarios of how Cathy's labour could go 'pear shaped' and insisted she would end up in hospital for them to pick up the pieces. Cathy proceeded with her plans and had a successful home birth at 10 days over her due date. She has just recently had her second successful home birth.

MCVic has seen correspondence from a Melbourne GP withdrawing her care from a pregnant woman that chose to have a home birth under the care of a private midwife. The letter reads: "I regret to inform you that I can no longer care for you at this practice due to the path you have chosen to take with the management of your pregnancy. You are therefore advised to seek medical care elsewhere".

Vicki Cox saw a GP/Obstetrician in the course of her pregnancy. He told her that he had to say that he disapproved of her plan to have a homebirth. When Vicki questioned why he had to say this, he responded that his medical indemnity insurers required him to.

<u>Collaboration between midwives and obstetricians and/or hospitals</u>

Women also experience a range of responses in their dealings with obstetricians and the hospital system.

Kelley Stewart wanted to enter into a shared care arrangement with a private obstetrician and a private midwife for her second pregnancy. She planned to give birth at home but wanted to have the back-up of an obstetrician in the event that complications arose. Kelley found it extremely difficult to find an obstetrician who was willing to enter into such an

arrangement. In the end Kelley had to keep her plans from her obstetrician as her obstetrician told her she could not be her doctor if she planned to homebirth because the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) Guidelines did not support home birth. Kelley had a successful home birth but had to pay the obstetrician the same fees that she would have had to if the obstetrician was her sole carer.

Many midwives encourage women planning a homebirth to make a back-up booking at a hospital in case transfer is required. Hospitals in Victoria vary in their receptiveness to such bookings and individual members of staff can also have negative attitudes towards them.

During the second half of her second pregnancy Svetlana Illarionov decided to have a home birth. Svetlana first pregnancy had ended in a cesarean. Her midwives advised her to book into a tertiary hospital in case complications arose during the labour and birth. Svetlana contacted the hospital and was invited in for a consultation. She attended the hospital for this consultation when she was 38 weeks pregnant. After waiting 2 hours she was seen by a doctor who began by telling her the risks of having baby at home after a previous cesarean. She listened carefully but, having already been provided with risk information by her midwives, was confident in her decision. The doctor asked her questions about why she had made the choice to have a home birth. She responded that she preferred to have care from professionals that she knew and trusted and that she did not want to have continuous electronic fetal monitoring during the birth. The doctor continued to push Svetlana to change her mind. Finally the doctor told her that she could not be booked into the hospital and that the hospital refused to provide her with care. The doctor left a message for Svetlana's midwife on her mobile phone. Svetlana was extremely upset by this appointment. Her midwives followed up and the hospital apologised and accepted her booking. Two weeks later Svetlana gave birth to her baby daughter at home.

Svetlana's story is of concern in the current discussion because it shows that there can be a disconnect between a hospital's policies and the views of individual medical practitioners within that hospital. MCVic is concerned that the proposed amendments require collaborative arrangements to be entered into with medical practitioners within hospital services rather than with health services themselves.

Michelle McRitchie had a successful home birth for her third baby but needed to transfer to hospital after the birth. Her experience reflects that of many women who transfer to hospital during or after a planned homebirth who find that the hospital system does not respect their decision to homebirth or the expertise of the midwife accompanying them.

Michelle experienced a post partum haemorrhage (PPH), which she felt was managed professionally and smoothly by her midwife with a transfer to hospital when her pulse would not return to normal (even though the blood loss had stopped). Michelle had already experienced a PPH in hospital with a previous birth and felt that she was in a safer environment at home due to the fact that her midwife did not leave her side and monitored her blood loss closely for two hours after the birth before they decided to transfer to hospital. An ambulance was called and arrived promptly. The paramedics respected the experience and knowledge of Michelle's midwife and worked with her. On arrival at the emergency department things were different. The doctors did not acknowledge the role of Michelle's private midwife and ignored her when she tried to offer a history of the situation. Michelle was not fully able to comprehend what was happening and kept looking to her midwife for

information. Michelle felt that both her and her midwife were left out of the decision making process.

The final example in this submission shows what is possible when midwives and medical professionals work together in genuine collaboration to facilitate women's choices. Anne Marie Jumpertz has two children who were both born in hospital.

Anne Marie's first baby presented as transverse (lying across ways in the uterus) and she needed to have a cesarean. Anne Marie had the constant support of an independent midwife throughout the pregnancy and birth who assisted Anne Marie in planning for a positive cesarean. Anne Marie had an electric oil burner and music of her choice playing in the operating theatre. She was never separated from her baby. Afterwards one of the theatre nurses came to see Anne Marie and told her it was the best cesarean they had ever seen at the hospital and that all cesareans should be like that. Anne Marie attributes this wonderful experience to the thoughtful consultation and collaboration of her midwife with the medical/ theatre team, including the obstetrician and anaesthetist. Her midwife continued to care for Anne Marie in the weeks after the birth.

Six years later Anne Marie was pregnant again. Early in the pregnancy she had concluded from careful research that it was very possible to have a vaginal birth after cesarean. Anne Marie wanted a consistent, ongoing relationship with her primary caregiver and chose an independent midwife as she felt that this would maximise her chances of having a natural birth if it was possible. Her independent midwife (a different one as she had moved) encouraged Anne Marie to meet with an experienced obstetrician in a nearby regional city just in case she needed his particular expertise. The midwife accompanied Anne Marie and her husband to the appointment. As the pregnancy progressed the baby presented as breech and Anne Marie continued to see the obstetrician and her midwife. Anne Marie found the contribution of her independent midwife to be invaluable as she considered the possibility of having a natural breech birth in a public hospital with the support of the obstetrician. After discussion and careful questioning the obstetrician agreed to all of Anne Marie's requests such as not having an epidural and standing to give birth to maximize the diameter of her pelvis. The obstetrician had experience in breech birth and respected the experience of Anne Marie's midwife. Anne Marie respected the judgement of the obstetrician and told him that they would follow his advice in labour if at any stage he felt he felt surgery was need. Anne Marie laboured at home in the care of her midwife until she transferred to hospital where approximately four or five hours later her daughter was born breech in a gentle natural birth with all of their requests respected.

Anne Marie's story highlights how collaboration can work in practice to provide high-quality woman-centred care. In this case collaboration was based on mutual respect between health professionals and was tailored to the needs of the individual woman.

Conclusion

MCVic submits that requiring midwives to enter into prospective collaborative arrangements with medical professionals is not the way to ensure that stories like Anne Marie's become more common in our maternity system. MCVic submits that mechanisms which facilitate collaborative practice are more likely to be effective in encouraging genuine collaboration that ensures that mothers and babies are safe and that women's choices are respected.

The stories above also point to the need for collaboration to be a two-way mutually respectful relationship. MCVic is very concerned that the amendments legislatively force midwives to enter into collaborative arrangements without any corresponding requirement for medical practitioners to collaborate with midwives.

MCVic submits that the proposed amendments should be withdrawn. Access to subsidised insurance, Medicare funding and the PBS should not be dependent on a midwife entering into a collaborative arrangement with a medical practitioner. Such a requirement would make women's options for maternity care subject to medical control and would severely limit the ability of women to make truly informed choices.

Thank you for considering our submission.

Yours faithfully,

Ann Catchlove
On behalf of the Committee of the Victorian Branch of Maternity Coalition