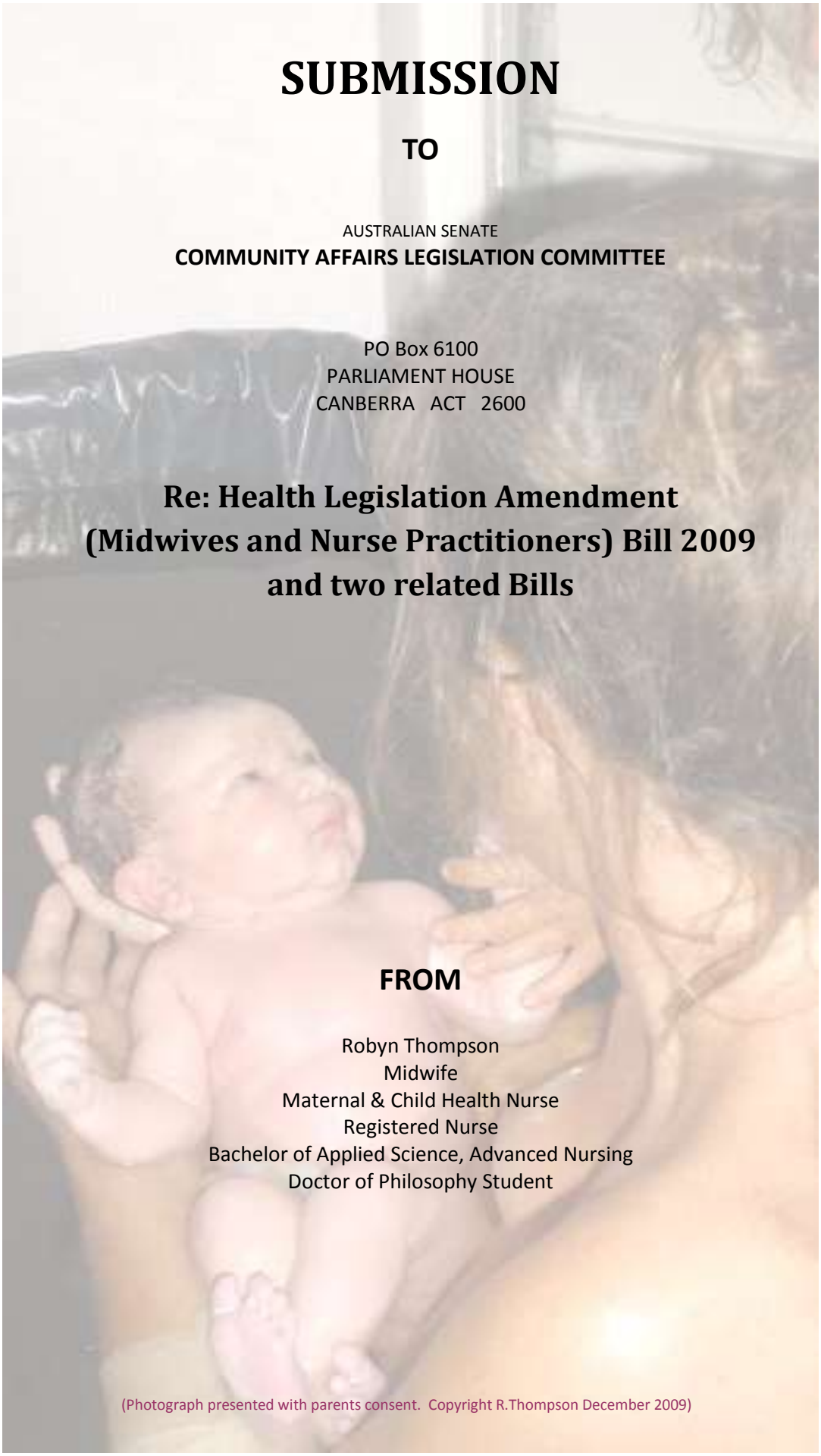
SUBMISSION

TO

AUSTRALIAN SENATE
COMMUNITY AFFAIRS LEGISLATION COMMITTEE

PO Box 6100
PARLIAMENT HOUSE
CANBERRA ACT 2600

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



FROM

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10th December 2009

Elton Humphrey
Committee Secretary
Community Affairs Legislation Committee
Australian Senate
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Email: community.affairs.sen@aph.gov.au

Dear Elton

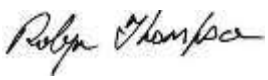
Thank you for the invitation to make a submission to the Senate Committee in relation to the proposed Government amendments on 'collaborative arrangements're the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and the two linked Bills, the Midwife Professional Indemnity [Commonwealth Contribution] Scheme Bill 2009 and the Midwife Professional Indemnity [Run-off Cover Support Payment] Bill 2009, circulated October 28, 2009.

This Submission is directed mainly from the perspective of a privately practising midwife for the past 25 years. On a broader professional scale I have also participated as a Board Director in the Submission of the Australian College of Midwives.

Thank you to the Senate Committee for scrutinising the full implications of these amendments and for ensuring that the rights of Australian women and midwives are protected.

Please accept the attached Submission in good faith.

Yours sincerely,



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Recommendation 1

I recommend that the amendments are immediately withdrawn

As a responsible, experienced midwife I ask that the Senate Committee to reject the provision for any proposed sub-regulatory authority of doctors over midwives in the form of "collaborative arrangements" for the purpose of triangulated access of Medicare, insurance and registration, that will impact on professional private midwifery practice and access for women to this midwifery service. I recommend the amendments be immediately withdrawn from the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.

Recommendation 2

I recommend that these anti-competitive, discriminatory and monopolising amendments are withdrawn.

The Government's amendments will veto midwives' from renewing national registration to practice. I ask that the Senate Committee reject any legislation that imposes anti-competitive, discriminatory or monopolisation and such documentation be immediately withdrawn from the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and that any existing anti-competitive processes be reviewed and removed.

Recommendation 3

I recommend that the amendments are withdrawn and equitable access to 'continuity' as defined be prioritised for rural and remote women.

The government amendment to the legislation will increase the difficulties in delivering intended access and choice for Australian women to midwifery services in rural, remote and metropolitan areas. Therefore, I ask the Senate Committee to strongly recommend that the government remove monopolising regulations, currently responsible for the demoralising professional contentions that will negatively impact on compatible, professional relationships and on women's reasonable access to maternity services with autonomous midwives.

Recommendation 4

I recommend that the amendments are withdrawn and all reference to collaboration be replaced with mutual consultation.

I request that the Senate Committee advance the demand to enquire what occurred behind the scenes to shape these amendments at the last moment, and for direct answers to the questions raised in the four points in this submission. And to also lead further change by withdrawing the negative and controlling language of "collaboration" and replace it with mutually consultative arrangements that include all maternity service providers and health service institutions. This will enhance the prospect of encouraging tangible, respectful professional relationships, repress professional competitive behaviours and provide improved services for all women by means of equality for midwives to 'institutional access agreement'.

Recommendation 5

I recommend that the amendments are withdrawn and that 'continuity' as defined in this submission be the yard stick for Australian health reform.

The Australian Governments maternity health reform in its current status has become a human rights issue. The Governments amendments will have an increased negative impact for Australian women's rights to make choices and for midwives to engage in those choices. The Governments amendments will also impact on mothers and babies' safety, morbidity and the existing and future of 'continuity' of midwife services. If the Government subverts private midwifery services and midwife autonomy into the authority of medical control, it is inevitable that women and midwives will be driven to the extreme to find diverse ways of avoiding the system and doctors. Such decisions are already permeating the social maternity environment in rural, remote and metropolitan areas. I strongly recommend the Senate advise the Government to remove the amendments forthwith.

Recommendation 6

I recommend that Senate Committee advise the Australian Government to establish a position for the first Commonwealth Principal/Chief Midwife.

The Australian Government Department of Health and Ageing appoint an experienced recently practising Midwife, with knowledge of all areas of midwifery service be appointed as the first Commonwealth Chief Midwife in recognition of the major role of the midwifery profession in the delivery of effective health care for Australia maternity services, women and babies.

SUBMISSION

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

Introduction

Thank you for your invitation to provide a second written submission to a Senate Inquiry Committee that is undertaking to address the above amendments. Thank you also to Senator Siewert for her extraordinary skill and determination in bringing the motion that referred the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills, together with the Government's proposed collaborative arrangements amendments, to the Community Affairs Legislation Committee for inquiry and report by 1 February 2010.

(Photograph presented with parents consent. Copyright R. Thompson Dec 2009)

I put to the Senate Committee that as an experienced midwife of 35 years, one has to ask what caused this national debacle. Why has such control of one profession over another been considered and imposed by the Federal Government? The rational consideration was that intrusion into the midwifery professions business by the Government and the medical profession of the day could only have been contrived by collusion. This became apparent in the public statement attributed to Dr Andrew Pesce, the President of the Australian Medical Association (AMA), recently:

Dr Pesce..."successfully lobbied Health Minister Nicola Roxon to make amendments to home birth legislation, ensuring that midwives would be denied Medicare payments unless they could prove they were working collaboratively with doctors." ..."the changes curtail a woman's right to choose how she gives birth, ***but Dr Pesce cites it as his greatest achievement so far as AMA president****". The Age, Reporter JILL STARK, November 29, 2009.*

Provoking this response soon after by the:

Powerful presentation of an audio-visual montage that attracted public comments (link below), demonstrating the wrath and strength of the female and family lobby. This presentation exhibits how this matter will continue to be conte**s**ted until a sensible resolution prevails. In fact, increased Government and medical intrusion into women's and midwifery business is so important to Australian women and midwives, it has revolutionised a unified approach resulting in consecutive rallies around the nation. Australian women and midwives demand the return of their rights. It is clearly evident that the unified rallies around the nation have reached the international community. Could this be the impetus for coordinated international rallies demanding that obstetric intervention in normal pregnancy and birth be investigated worldwide?

http://www.onetruemedia.com/otm_site/view_shared?p=9ef3e42e693eab03a54a39&skin_id=601

Dr Pesce failed in his media statement to admit that:

The truth behind the AMA (the union) and the Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG) joint persistent pressure, is to prevent the autonomy of midwives to function within their full scope of midwifery practice, because the unspoken fear is associated with reduced income, due to the balancing of professional and social inequities. Current Australian health reform originally intended in part, to return midwives to their rightful professional place in Australian society. This reform with discriminatory insurance issues resolved, would have enhanced the means of sharing educated skills across the professions, projecting benefits in the best interest of the health of Australian women and babies. Midwives are not territory encroaching, or competing with the medical profession, they are simply retain the right to offer autonomous midwifery services to healthy women. In terms of a return to autonomous midwifery they do foresee a reduction in multiple medical interventions, and in time the potential to expand midwifery services to approximately 80% of healthy Australian women.

Addressing the Terms of Reference

a) Whether the consequences of the Government's amendments for professional regulation of midwifery will give doctors medical veto over midwives' ability to renew their licence to practice

If the Government's amended legislation is passed, it will mandate midwives to have 'collaborative arrangements' with individual named doctors prior to, or contingent upon midwives being able to register with the Nursing and Midwifery Board of Australia, or be eligible for Commonwealth Medicare rebates or Commonwealth Indemnity Scheme support. In this case the government will have deliberately sanctioned doctors with sub-regulatory authority over midwives and their practice. This deliberately renders midwives to duplicated regulations via the National Registration Board as well as the medical profession. For any government to condone one health profession to have power over another is untenable. Would any other professional group accept being vetoed by the medical profession? Is this type of decision making in the best interests of women, their babies and the public?

I recommend that the amendments are withdrawn.

As a responsible, experienced midwife I ask that the Senate Committee to reject the provision for any proposed sub-regulatory authority of doctors over midwives in the form of "collaborative arrangements" for the purpose of triangulated access to Medicare, insurance and registration, that will impact on professional private midwifery practice and access for women to this midwifery service. I recommend the amendments be immediately withdrawn from the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.

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

Inclusive of the issues raised in the section above, the government's influence on the 'health care market' will increase the existing anti-competitive control that medicine has over other professions.

Some midwives have continued to provide midwifery services without access to indemnity insurance since 2001. Discrimination and monopoly has controlled women who pay the Medicare levy and employ private midwifery services in the home, this choice of service has prevented them from retrieving Medicare benefits. Women who continue to employ midwives for personalised care accept the insurance risk. They are informed from the outset that reasonable access to indemnity insurance for midwives and midwifery services is denied by market control of the insurance industry. Conversely, women who pay the levy and engage a medical practitioner to birth in hospital receive the full Medicare rebate. Medicine clearly monopolises access to, and distribution of, the Australian tax payer's health dollar, including access to insurance for midwives because of the medically monopolised insurance industry. This effectively means the women who birth at home and pay the Medicare levy are subjected to discrimination in relation to distribution of the health dollar because

of medical monopoly over access to Medicare provider numbers, access to health service systems and access to professional indemnity insurance. The government's amendments impedes fair access to the health market for quality (midwifery) maternity services and is incongruent with the fee-for-service principles proposed in the National Maternity Review (2009).

I recommend that the amendments are withdrawn.

The Government's amendments will veto midwives' from renewing national registration to practice. I ask that the Senate Committee reject any legislation that imposes anti-competitive, discriminatory or monopolisation and such documentation be immediately withdrawn from the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and that any existing anti-competitive processes be reviewed and removed.

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

The government and the health professions have equal responsibility to protect the public. The public is not protected when access and choice to a range of maternity services is monopolised by one profession. The obstetric profession holds full control of 'obstetric beds' in public and private hospitals; the only access to services is by a doctor's name. Access to Medicare rebate, pathology, radiology, pharmacy for example is only by doctor's name (with provider number).

Although there are known attempts to hinder the process, the only area of maternity services that the obstetric profession does not control is women's choice to engage and receive the services of a midwife in the home. Midwives believe that this type of service, public or private, should be accessible by choice to more Australian women. The women who would benefit from the services of a known midwife in particular, are the rural and remote women. The discrimination and disruption to their families, the long tiring travel and the risk of birthing in transit, complicates the physical and emotional health of these women. Improvements in the current health status of rural and remote women would be dramatically improved if equal, non competitive access was available in their communities, or in their homes.

To protect the public the government has a responsibility together with non competitive professionals to provide equality of access for women to midwives with insurance and Medicare rebate, including access for midwives to rural, regional and metropolitan hospitals near their communities. Midwives also have the right to assist women in a process that enables access to a consultative medical team when consultation or transfer to medical facilities is deemed appropriate. The metropolitan demand for midwifery services is consistent; the rural and remote women have very little choice of access to medical or midwifery services located in or near their communities or in their homes. In the metropolitan areas for example, I consistently receive at least three requests per week from women looking for their 'own' midwife including many requests from graduate midwives looking for access to mentoring to gain experience in 'out of hospital' settings and to prepare for the impending national requirements.

I recommend that the amendments are withdrawn.

The government amendment to the legislation will increase the difficulties in delivering intended access and choice for Australian women to midwifery services in rural, remote and metropolitan areas. Therefore, I ask the Senate Committee reject any government move that legislates monopolising regulations, and to remove any reference that attracts or imposes irresponsible, demoralising, professional contentions that will affect compatible professional relationships and impact on women's reasonable access to maternity services and autonomous midwives.

d) Why the Government's amendments require 'collaborative' arrangements' that do not specifically include maternity service providers including hospitals.

First, I would have to ask the following questions: why are midwives the only professionals under the Health Practitioners Act to be legislated to collaborate with another profession? What was the intention behind this legislation? Who made this decision, and on what grounds did they come to this decision?

Second, I offer an explanation to the Senate Committee as to why I choose not to succumb to 'collaborating' under controlling circumstances that appear in amended legislation developed by the current Labor Government. To be forced to provide services for women under the authority of another professional, to relinquish my professional autonomy after 35 years of midwifery service, 48 years in the Australian health system and 25 years in private midwifery practice are unacceptable and untenable. To impose legislation that prevents my practice is disrespectful as an Australian professional and for the women who I have served and will continue to serve. I do make it clear however, that I will continue consulting with whomever the women decide is the best medical person or hospital facility to provide them with any additional service/s or care. Responsible, midwives will facilitate any move to seek medical advice when appropriate, and respectfully with their qualifications and experience they do not need to collaborate or ask permission of the medical profession to practice midwifery. Midwives do have a responsibility to mutually consult and share documentation with consent that benefits the best possible care and outcome for women who employ midwifery services.

Third, it is important to inform the Senate Committee that there are existing, excellent and respectful consultation processes between midwives, doctors and hospital service providers around the nation. Some of these arrangements have been in place for at least a quarter of century. Why wouldn't a sensible Government and other decision makers seek to mirror this appropriate consultation process? Why wouldn't they build on the experiences of existing, functional, and mutually respectful professional relationships that demonstrate capable, established and fundamental processes? Why instead, have the decision makers gone to extreme and costly lengths, to establish controlling mechanisms that legislates for the medical profession to preside over and subvert midwife autonomy and equitable access to Medicare and insurance?

Fourth, advisedly it is important for the Senate Committee to consider that Australian midwives practice under the International Confederation of Midwives (ICM) *International Definition of a Midwife* and that undoubtedly means qualified midwives are within their rights to provide midwifery care for and with healthy women and infants in any setting, and have non discriminatory access to mutually consultative arrangements when required. Australian midwives are professionals in their

own right; they are separate from the nursing profession and no longer 'take orders' from doctors like nurses do. Midwives arrange consultative working relationships with doctors and other health professionals when appropriate, without government or medical control and they do so in best interests of their profession, the women and babies.

Midwives are no longer controlled by the medical profession and it seems that is the hardest part of the Australian health reform for the medical profession to first understand, and second deal with and accept. University educated, midwives are regulated and currently registered under state and territory laws until July 2010. They provide professional midwifery services across the full scope of midwifery practice, they are scrutinised by midwifery standards, codes of conduct and ethics. Responsible midwives are guided by the Australian College of Midwives (ACM) consultation and referral principles that were developed 'in consultation' with multiple professional groups. Why would anyone in the Australian Government, the medical profession or possibly the nursing profession choose to be party to amending legislation that restricts midwifery practice, subverts midwives to medical control and reflects negatively on much needed health reform that offers functional benefits to women, midwives and other professionals?

I recommend that the amendments are withdrawn.

I request that the Senate Committee advance the demand to enquire what occurred behind the scenes to shape these amendments at the last moment, and for direct answers to the questions raised in the four points above. And to also lead further change by withdrawing the negative and controlling language of "collaboration" and transform it to mutually consultative arrangements that include all maternity service providers and health service institutions. This request is to enhance the prospect of encouraging tangible, respectful professional relationships; to desist professional competitive behaviours and to provide improved services for all women by equality for midwives to 'institutional access agreement'.

e) Whether the Government's amendments require will have a negative impact on safety and continuity of care for Australian mothers and their babies

As previously mentioned the Government and the professions are jointly responsible for public safety. Most midwives and many doctors do not go about their professional business with the intent to do harm. Doctors and midwives are not exempt from adverse events. Adverse events do and will continue to occur, that is an accepted human element, no one person or professional can guarantee 100% perfection for another, it is not possible in the human or any other species.

Further scrutiny of obstetric practice is required in light of the evidence of the emotional and physical trauma that women experience during medical interventions, including separation of mothers from their babies at birth, the effects of maternal drug dosage on unborn and newborn babies and the decline in exclusive breastfeeding due to delayed early breastfeeding, the replacement of breast milk by the use of other species milk products in the early hours, days and weeks, due to excessive and often painful and unnecessary medical interventions. The Australian Caesarean Section rate apart from any other intervention now exceeds 30% nationally; the World Health Organisation recommends 10-15%.

'Continuity' defined, is the provision of maternity care for each woman by the same midwife from early pregnancy, through labour and birth and up to the sixth postnatal week. Currently in Australia, the private practice midwife is the only professional who provides 'continuity' for women through the full scope of midwifery services. The woman who employs a private midwife is contracting that midwife for the whole journey, in her home, from early pregnancy, through labour and birth and up to six postnatal weeks. Many women return to the same midwife for successive journeys, some for more than six babies. Others are providing continuity for the daughters of the mothers (the grandbabies) they assisted years ago. Some women require consultation or transfer from the home for varying degrees of medical assistance, this is not to be criticised, rather recognised as respected collegiate consultation or referral, inevitable for a percentage of women in any practice setting.

Many models aspire to providing continuity of care, but unless the complete episode as defined is with the same midwife through the full spectrum, **it is not 'continuity'**. Segments of care in other models maybe provided by one or more midwives or doctors for a period of time, it is rare for the same midwife or doctor to be the only person to provide the full scope of the service from early pregnancy to six postnatal weeks in any other service model. Generally segments of care are provided by multiple midwives and doctors and doctors never remain for the whole labour and birth. They utilise and expect private and public hospital employed midwives, who may have never met the woman, to provide that segment of the service while a collective of employed midwives generally provide some postnatal care. Eruptions of various models around the nation have generally provided a team or group service, in these settings the woman is not guaranteed the same midwife or doctor at any one point in time and in hospital settings the woman is subjected to early discharge policies. Women who are transported through the public system are conveyed via various departments and can never be guaranteed a familiar person for the complete journey.

Why is this Government reform focused negatively on the established private practice midwifery model? Reform ought to be aimed at shift work or task models that have no connection with continuity as defined. Reform could be achieved by a sensible approach of removing healthy women out of segmented systems into community and home based midwifery services. Services for women, where they are connected with one midwife who has access to midwifery, medical, hospital and other support systems through the full spectrum of care, and includes students who will learn about normalising maternity services. Obstetricians would be freed of their excessive throughput to be available within private and public hospitals to provide medically skilled services; the benefit would be recognised by a reduction in intervention rates and the overwhelming demand on institutional resources.

Women and midwives would not be forced to take drastic actions to ensure their human and professional rights are recognised in a patriarchal society. Women over history have fought and won many battles, it is common societal knowledge that Australian women and midwives do not intend to give up on this fight. They have and will continue to challenge the injustices of intrusion by collusion that results in human rights issues being surreptitiously framed in Australian legislation. Midwives, women and interested others of the world are watching, responding and waiting for the next move.

I recommend that the amendments are withdrawn.

The issues of legislation, national registration, insurance, Medicare rebate and collaboration (mutual consultation) has pushed midwives and women to the limits, it is now a human rights issue. The Governments amendments will have an increased negative impact for Australian mothers and babies on safety, morbidity and the existing 'continuity' of services. If the Government forces private midwifery services and midwife autonomy under medical control, it is inevitable that women and midwives will be driven to the extreme to find diverse ways of avoiding the system and doctors. Such decisions are already permeating the social maternity environment in rural, remote and metropolitan areas. I strongly recommend the Senate advise the Government to remove these amendments forthwith.

f) Any other related matter

The Australian Greens succeeded in bringing scrutiny to Federal Government proposals that would effectively give doctors control over who can practise midwifery.

The Government's and obstetrics' determined intrusion and attempted control of midwifery practice and professional midwifery matters is clearly driven by the unspoken fear of reduced input and throughput of women and babies resulting in loss of income and potential gynaecological work . Formal collaborative (mutually consultative) arrangements between professionals should not be a legislated condition of professional practice. **It is unacceptable, an untenable proposition, it will not work, and it will create diverse counter actions, adding more controversy to the existing debacle.**

Mutually respectful consultative arrangements are a professional responsibility; it is not a matter of control over any one profession or group. Mutually respectful consultation includes the most important person, the woman, who is responsible for her own consent and her right to choose who she will consult with, and where she will transfer to if required. **This process successfully exists and can be expanded upon if sensibility for a responsible approach to mutual consultation not negative collaboration is achieved. Leave it up to the professionals they are qualified and experienced at knowing what to do.**

It is asserted that few midwives will work under the control of Obstetricians in obstetric practices over long periods. Midwives working to their full potential, according the ICM Definition of Midwife, offer much more in personalised woman and baby friendly services. Midwives assist in normalising birth and breastfeeding when they are side-by-side with women through the spectrum of a woman's journey. **This process already functions successfully; it can be expanded with a responsible approach to mutual respectful consultation with individual doctors, midwives and hospital employees. Remote and rural women can benefit from equality of maternity services with a decentralised shift of medically controlled tax payer resources into communities and home based midwifery care.**

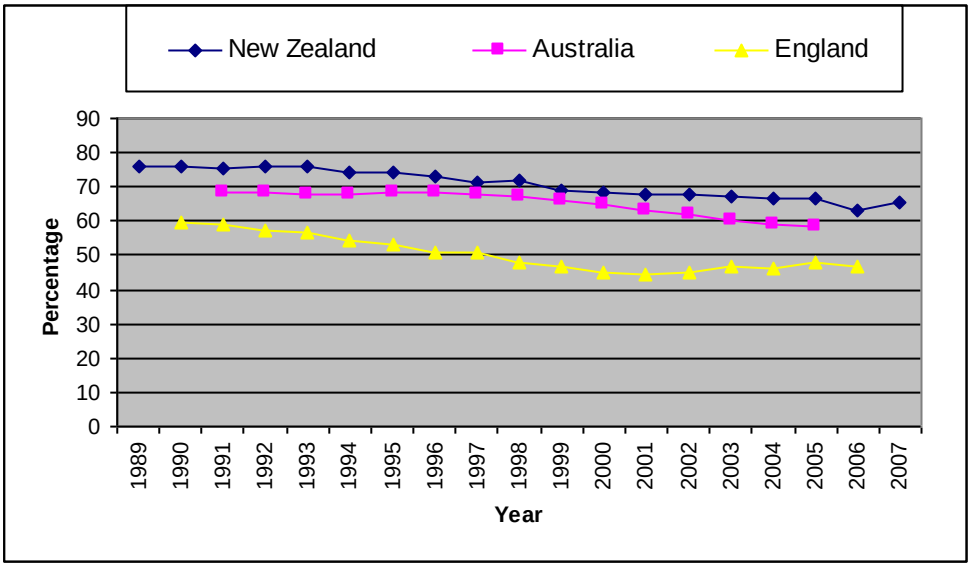
The President of the New Zealand College of Midwives (NZCOM), Dr Karen Guilliland on December 8th 2009 shared two documents that are part of a manuscript for a yet unpublished book. The first document is a preparatory letter from the NZCOM to the National Health Board, revealing evidence of the cost effectiveness of the current New Zealand model. In this letter the NZCOM shows evidence that Lead Maternity Care (LMC) provided by a midwife (equivalent to 'continuity' as

defined in this submission) impacts positively on the health and well being of New Zealand women and babies. These documents can be produced for perusal by the Senate Committee:

> ...by 2009 most of the maternity service has shifted from a hospital based one to community care with over 94% of women having an LMC and over 80% of those having the majority of their care by a known midwife. This continuity is something parents value highly. The College receives 25,000 evaluation forms from midwife clients every year giving testimony to this. (NZCOM, letter dated 8 December 2009, Evidence of cost effectiveness of current national model).

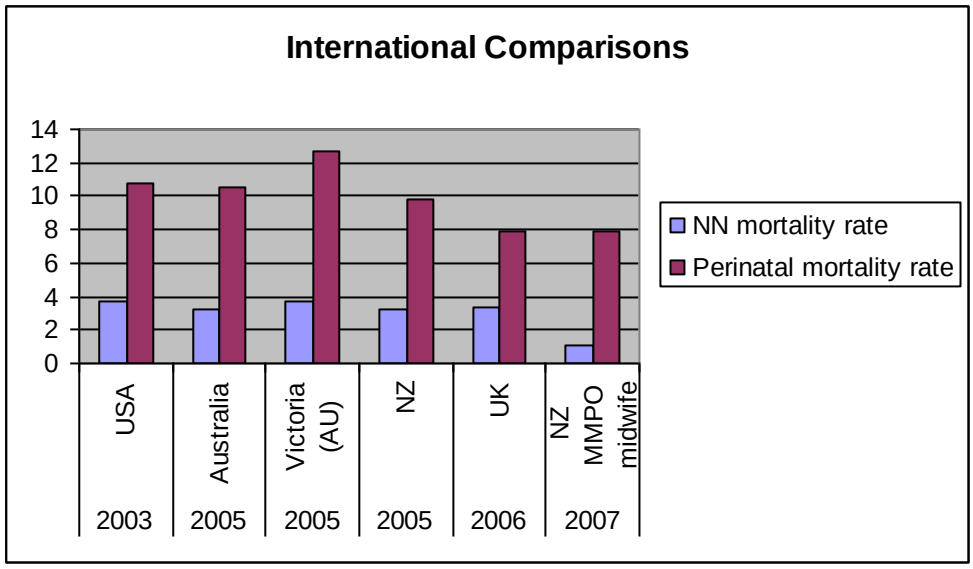
The second document identifies *International outcomes and comparisons* with *New Zealand maternity services* on (a) Maternal Mortality and (b) Numbers of Births in New Zealand. The following two graphs were sourced with permission from the NZCOM for this submission.
The New Zealand birth rate remained stable until 2004, since then the rate has continued to rise with the highest number in 2007 of 64,503. The high normal birth rate is attributed to 'continuity' of care from a midwife and the quality of maternity service provided (Figure 1).

Figure 1: Comparison of normal birth rate between New Zealand, Australia and England



Most western countries, like New Zealand, have low perinatal mortality rates which largely reflect the high standard of living and accessible health services in these countries. The high normal birth rates in New Zealand are accompanied by low foetal and baby death rates (perinatal and neonatal mortality) when compared internationally (Figure 2) (NZCOM).

Figure 2: International comparisons of perinatal and neonatal mortality rates



Sources of the data (NZCOM):

(a) UK data: CEMACH Perinatal Mortality report (Confidential Enquiry into Maternal &Child Health, 2008). **(b) USA data:** The Fetal and Perinatal Mortality report (MacDorman, Hoyert, Martin, Munson, & Hamilton, 2007) CDC. **(c) NZ data** Statistical Information on Hospital based Maternity events 2005 (Ministry of Health, 2008). NZCOM 2005-7, Maternity and Midwifery Providers Organisation (MMPO), Reports. **(d) Australian Data:** Australia's mothers and babies 2005 from the Australian Institute of Health and Welfare National Perinatal Statistics unit (Laws, Abeywardana, Walker, & Sullivan, 2007). The Australian Victoria data is from the Annual Report for the year 2005 (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2007).

The Australian Government would be wise to take a lead from the NZCOM and the New Zealand Government to administer a proven successful model in Australia and to consider combining resources to jointly measure and publish outcomes. The benefits for Australia and New Zealand would be the co-production of extensive international research.

CONCLUSION

A responsible approach to effect the transition to national registration, and to assist with reasonable change to the maternity component of the Government's health reform, is for the Australian Government (and the medical profession) to acknowledge and accept that midwifery and nursing are separate professions with different scopes of practice. It is asserted that the Government will be better advised about the midwifery scope of practice, education and professional and other relevant issues with the appointment of an experienced Midwife as counsel to the Minister for Health & Ageing for successful reform. **To avoid any further pitfalls, I recommend that Senate Committee advise the Australian Government to establish a position and appoint the first Commonwealth Principal/Chief Midwife to advise the Health Minister on all matters pertaining to midwifery.**

(Photograph presented with parents consent. Copyright R. Thompson Dec 2009)

Thank you.

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Questions raised in this submission

- Why has such control of one profession over another been considered and imposed by the Federal Government?
- Could this result in international rolling, rallies demanding that obstetric intervention in normal pregnancy and birth be investigated worldwide?
- Would any other professional group accept being vetoed by the medical profession?
- Is this type of decision making in the best interests of the women and the public?
- Why are midwives the only professionals under the Health Practitioners Act to be legislated to collaborate with another profession?
- What was the intention behind this legislation? Who made this decision and on what grounds did they come to this decision?
- Why wouldn't a sensible Government and other decision makers seek to mirror an existing appropriate consultation process?
- Why wouldn't they build on the experiences of existing, functional, and mutually respectful professional relationships that demonstrate capable, established and fundamental processes?
- Why instead have the decision makers gone to extreme and costly lengths, to establish controlling mechanisms that legislates for the medical profession to preside over and subvert midwife autonomy and equitable access Medicare and insurance?
- Why would anyone in the Australian Government, the medical profession or possibly the nursing profession choose to be party to amending legislation that restricts midwifery practice, subverts midwives to medical control and reflects negatively on much needed health reform that offers functional benefits to women, midwives and other professionals?
- Why is this Government reform focused negatively on the established private practice midwifery model?

Reference Sites

Australian College of Midwives
htpp://www.midwives.org.au

ACM Practice Guidelines: National Midwifery Guidelines for Consultation and Referral
http://www.midwives.org.au/ForMidwives/PracticeGuidelines/tabid/308/Default.aspx

ACM Continuing Professional Develop Programme
http://www.midwives.org.au/ForMidwives/MidPLUSContinuingProfessionalDevelopment/tabid/310/Default.aspx

ACM Midwifery Practice Review
http://www.midwives.org.au/ForMidwives/MidwiferyPracticeReview/tabid/311/Default.aspx

Australian Nursing and Midwifery Council
http://www.anmc.org.au/

Australian National Midwifery Competency Standards (2006)
http://www.anmc.org.au/userfiles/file/competency_standards/Competency%20standards%20for%20the%20Midwife.pdf

ANMC National Midwifery Code of Ethics (2008)
http://www.anmc.org.au/userfiles/file/research_and_policy/codes_project/New%20Code%20of%20Ethics%20fo%20rMidwives%20August%202008.pdf

ANMC National Midwifery Code of Professional Conduct (2008)
http://www.anmc.org.au/userfiles/file/research_and_policy/codes_project/New%20Code%20of%20Professional%20Conduct%20for%20Midwives%20August%202008.pdf

International Confederation of Midwives
http://www.internationalmidwives.org/

ICM The International Definition of the Midwife 1972 and its amendments of 1990. ICM Adopted 19 July 2005
http://www.internationalmidwives.org/Portals/5/Documentation/ICM%20Definition%20of%20the%20Midwife%202005.pdf

ICM International Code of Ethics for Midwives
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