

## **Midwife in Private Practice Subcommittee of the ACM QLD Branch**

### **Introduction**

In 2006 a Midwives in Private Practice (MIPP) Subcommittee of the Australian College of Midwives in Queensland was established to support a decreasing number of midwives in private practice in this state. The group has met regularly over the last few years. There are a handful of midwives working in private practice in Brisbane and the surrounding area. There are many more who would consider private practice if current barriers were addressed. Most of these midwives predominantly work providing homebirth services although some also provide antenatal care and support women during hospital births, where they have no official clinical status.

The number of midwives in private practice in Queensland has diminished. Outside Brisbane and the surrounding coastal area there are known to be 2 midwives in Toowoomba, one in Theodore, one in Mackay and possibly one further north.

We are happy to attend the Senate Committee hearing to provide verbal advice about this submission.

### **The current model of homebirth care**

Midwives in private practice provide full physical, emotional and psychosocial care of mother (and baby) from early pregnancy until approximately six weeks post birth. Most midwives in private practice are engaged by women relatively early in pregnancy, with occasions of preconception engagement, to discuss nutrition and health concerns. Women have a booking visit which can take around two hours where all aspects of health are checked including blood pressure and urine, a full health history is taken, obstetric history is taken and any risk factors are discussed, mental health and associated issues are addressed. Women receive emotional and social support and education about lifestyle choices and factors. A booking visit may also occur at a public hospital, as a back-up in the event of planned homebirth that may require transfer of care. The midwife in private practice then follows currently accepted visiting schedules and sees the woman frequently and as required throughout pregnancy. Midwives can refer to the Australian College of Midwives “National Midwifery Guidelines for Consultation and Referral” (2008)<sup>1</sup> to provide guidance when there is an alteration in the clinical picture for an individual woman. Midwives generally provide continuity of care for women throughout pregnancy and birth (usually in the woman’s home) and for several weeks after birth who fall within these guidelines. In situations where this does not occur, the woman and midwife follow the appropriate consultation and referral pathway and the woman’s right of informed choice and right of refusal are also supported within these guidelines.

Women contact their midwife when labour begins. The midwife attends the home when she is required bringing with her equipment, including in most instances: a Doppler for monitoring the baby’s heart rate, oxygen administration equipment and bag and mask for resuscitation, syntocinon, intravenous cannulation equipment and fluids in case of haemorrhage, catheterisation equipment, scales to weigh baby, suction equipment for the baby, equipment for suturing and equipment to monitor blood pressure, temperature and

other vital signs. The midwife monitors the wellbeing of the mother and baby including vital signs for the mother and the baby's heart rate. The midwife provides full physical and emotional care for the mother and the family during the labour and is there for the length of labour. Again, the midwife refers to the ACM Guidelines for consultation and referral if necessary if there is deviation from normal progress in labour, and has processes in place for transfer to hospital if required. A second midwife may come when the birth is imminent. Once the baby and placenta are born the midwife provides care for mother and baby, observing physical health of both, may suture the mother if required, helps to initiate breastfeeding and early bonding and parenting. There are no strict timelines placed on women for the birth of either the baby or the placenta, this is assessed on a client by client basis. Likewise, after the birth, the midwife will stay with the family for as long as she is needed.

The midwife completes birth documentation, birth notification and registration, and data collection. The midwife then usually attends the woman at least daily for three days and collects any neonatal screening that is required; again referring mother or baby if any concerns develop that is beyond the scope of the midwife. The midwife spends a great deal of this time assisting the mother to gain confidence with breastfeeding and caring for her baby. She also monitors the mother's emotional wellbeing and assists her in dealing with any concerns which may arise.

The midwife continues to see the woman for around six weeks after the birth, weighing the baby, checking the mother for physical and emotional issues, making sure that breastfeeding is going well. The amount of contact is usually determined by both the midwife and mother. Usually at some point the midwife will sit and discuss the birth with the mother and family (often many times), forming an informal type of "debrief" which helps women and their partners to understand the birth better. If there are any concerns, the midwife can see the woman for longer, but will also refer women on to child health nurses or to GP's to continue health and development checks for the baby.

Midwives in private practice currently provide antenatal services in the community, in clinics or in the woman's home. They are only able to provide birthing services in the woman's home as all clinical rights are removed once the midwife enters a birthing institution. Postnatal services are also provided in community based clinics or in the woman's home.

Changes and further development of the model could potentially see the context of practice to include private midwives working within private and public hospitals. Although it is hoped that the introduction of these bills will provide mechanisms to support private midwives having visiting rights to hospitals, this will provide an option for a *different* type of birthing woman, who *wishes* to birth in hospital. There will still be women who want the choice of birthing at home with their own private midwife. As more women choose a private midwife for their maternity care, in fact, it follows that *more* women may choose to birth their baby at home, when they are well supported and better informed of their options.

## **Quality and Safety in Homebirth**

A large amount of research demonstrates the safety of homebirth. In the last 12 months the largest study of homebirth (over 500,000 births) demonstrated “that planning a home birth does not increase the risks of perinatal mortality and severe perinatal morbidity among low-risk women, provided the maternity care system facilitates this choice through the availability of well trained midwives and through a good transportation and referral system”<sup>2</sup>. Many other studies regarding safety of homebirth have been summarised by Newman (2008)<sup>3</sup> and have been considered and summarised in the homebirth policy for South Australia (2007)<sup>4</sup>.

## **Problems with the proposed legislation**

### **1. Funding (exclusion of care outside the clinical setting – i.e. homebirth)**

The proposed changes to the Medicare system and Indemnity to include midwives in private practice are to be applauded. The exclusion of birth at home from the changes in funding is discriminatory and a matter of public safety as it precludes homebirthing women from accessing professional midwifery care. These women do not see birthing in hospital as a viable option for themselves. The exclusion of homebirth from Medicare funding makes this a barrier for many women wanting homebirth care.

The other potential barrier is for women in remote areas, including Aboriginal and Torres Strait Islander women, where there may be a desire to establish services utilising Medicare as a funding mechanism and providing birth on country. Whilst there is a significant amount of literature demonstrating that this is a choice Aboriginal women would like to make<sup>5 6</sup> and supporting this as a method of improving outcomes it will be impossible to provide this service under the legislative changes.

Less than one percent of Australian birthing women have homebirths with most making the choice of private midwifery care.<sup>7</sup> They deserve access to the same funding mechanisms provided to women choosing other options, for example an elective caesarean section with no medical indication. It follows, as mentioned above, that the proportion of women who will choose homebirth in the future is unestimable as more women gain access to private midwifery care.

The “gold standard”<sup>8</sup> of continuity of carer is possible with a re-organisation of maternity services. Under the proposed legislation midwives will be unable to charge above the scheduled fee for their services. This lack of equity with other health professions is against principles of fair trade and risks polarizing the professions.

Private midwifery care, under proposed changes, would be solely funded through a series of Medicare item numbers. The income this must provide the private midwife must take into consideration:

- educational resources;

- equipment used;
- around 10 antenatal visits, each being up to two hours long;
- being on call 24 hours a day, 7 days a week for the entire antenatal, birth and postnatal period *for each women cared for*;
- attending the woman throughout *any* length of labour and birth;
- around 6 postnatal visits, up to two hours long per visit, *plus* as many visits as required for breastfeeding support and assistance;
- the attendance of a second midwife at the birth;
- travel time and cost;
- time for completing paperwork;
- time and cost of accounting/running a business;
- time and cost of professional development.

If midwives must charge only the schedule fee, and not above this fee, then the overall role of the midwife must be considered when fees are being established. Whilst the government's support of public access to private midwives as a free service to women is to be absolutely applauded, we anticipate equity with our private obstetric colleagues where funding is concerned. Overall, private midwives will still provide Medicare with cost savings as intervention and complication of normal births will be minimized.

## **2. Indemnity (exclusion of care outside the clinical setting i.e. homebirth)**

The exclusion of homebirth from the legislation being discussed creates significant problems for registered midwives currently providing homebirth care and for the women who employ them. The overlap of the legislation discussed in this Senate submission and the Health Practitioner National Regulation law (Bill B) creates a situation whereby midwives providing homebirth care will be acting outside their registration by not holding Indemnity Insurance to cover their practice. This is absolutely unacceptable.

Midwives currently providing homebirth care are in high demand. This indicates that homebirth is a choice that women want to make. Currently in Queensland there are no public homebirth models in existence. Whilst state reforms have seen the introduction of two birth centres over the last 5 years and one further birth centre model planned, the reform process is slow. It is unlikely that state based homebirth models would be able to be commenced and implemented within 12 months. Therefore it is likely that following the implementation of this legislation in July 2010, women seeking homebirth services will be able to make one of three choices:

1. To birth at home on their own, unattended by a health practitioner
2. To have an unregistered, unregulated person attend their birth
3. To birth in hospital (this is not seen as a viable option to homebirthing women, otherwise they would have chosen it to begin with).

For many women, birthing at home alone is seen as a more desirable and even safer choice than birthing in hospital.

Private midwives who currently provide homebirth care will have the following limited choices:

1. If they are eligible, to seek access to Medicare and to provide care under this system for hospital based birth, providing care to a different clientele
2. To relinquish their registration and to provide care in an unregulated fashion;
3. To continue to be registered and continue to provide homebirth care, risking disciplinary action and deregistration, as well as hefty fines for themselves and others;
4. To leave the profession;
5. To leave private practice and work in hospital (this is not seen as a viable option for these midwives, otherwise they would have chosen it to begin with);
6. To leave the country and practice elsewhere (New Zealand, Canada for example), taking their experience and expertise with them.

The exclusion of homebirth from indemnity has been suggested to be a mechanism of “tightening up” homebirth and “bringing it in to state based services”. The legislation as it is proposed will have entirely the opposite effect. Provision of indemnity insurance could be attached to a model of homebirth which enables quality and safety mechanisms to be built in. Exclusion of homebirth and the deregistration of midwives providing homebirth care excludes any potential quality and safety processes around homebirth care.

Quality assurance mechanisms including registration requirements, ongoing evidence of continuing professional development, some kind of credentialing process (eg Australian College of Midwives Midwifery Practice Review) and data collection could be attached to indemnity. A potential model of care will be discussed below.

Two potential solutions exist to the indemnity problem. The first is the addition of a clause to the Health Professions National Regulation legislation excluding midwives providing homebirth care from the requirement of professional indemnity to cover all areas of practice. The second would be for the Federal government to extend the indemnity subsidy that it intends to provide to include homebirth care.

The first solution is a short term solution as it does not provide a safety mechanism for homebirth consumers. Homebirth consumers have the same right to indemnified care as all other health consumers. The second solution requires the government to engage with private practicing midwives providing homebirth care to develop accurate actuarial information in order to seek accurate quotes for insurance from the insurance industry.

### **Exclusion of homebirth – what are the consequences?**

Private practice midwives currently provide the vast majority of homebirth care within Australia. State based models provide care for a limited number of women and are generally only available in very small areas confined to metropolitan regions. There are no state based homebirth models in Queensland. We would be happy to provide verbal advice regarding the lack of prospect of developing state based homebirth models in Queensland. Private midwives will be unable to provide homebirth care under proposed conditions of registration. This will mean that the midwives in Australia with the

experience to provide this service will be actively prevented from doing so. The loss of homebirth expertise will have a significant impact on the safety of women.

A phenomenon becoming more prevalent in Queensland is the idea of “freebirth” which is giving birth without a trained care provider (i.e. midwife or medical practitioner). The philosophy behind “freebirth” (Unassisted Childbirth UC) is:

*that if the mother is left to birth without any birth authority other than herself to rely on, she will birth as she is physiologically meant to.*

*With no outside authority to look to and validate her actions, the mother will turn deep within herself and be open to the primal birthing knowledge that is innate in all of us women. We may not consciously know what to do in the event of so and so complication, but our bodies and our instincts do. Put simply, UC is a leap of faith, and you don't even have to be religious to do it.*

*The safest and most responsible birth is one where the mother knows that she needs no one present to birth her baby other than herself. She knows that she has all the necessary primal knowledge that will make itself available to her at the right times. She knows this knowledge will manifest in actions, feelings and instinct, not conscious, logical thought, and it will prevent and avoid most problems. She educates herself and prepares herself for birth by confronting her fears and researching the “what if’s”, keeping in mind that all she needs is trust in birth, in her abilities and in her baby. She is positive and confident. Birth is a joyous experience, and she will claim it for her and her baby!”<sup>9</sup>*

A further addition to this phenomenon is that there are some doulas providing care for women having “freebirths”. A doula is;

*A support person who will stay with you throughout your entire labour and provide physical comfort, encouragement reassurance and information.<sup>10</sup>*

Doulas are not required to have any sort of training, although most have some, nor are they regulated in any way, however there are “registers” which informally list doulas. The Australian doula register states the following limits of service for doulas:

*The doula has no clinical responsibility and hence does not undertake bio-medical observations even if she has been trained to do this in a different course. The doula does not support any client until she is certain that this client understands that the doula has no clinical ability and no clinical responsibility. The doula does not plan to support a home birth that is unattended by a clinical care provider. The doula does not judge or make negative comments about any medical or midwifery intervention. The doula does not give advice to the laboring woman. The doula does not prescribe treatment.*

*The doula does not support a woman having a home birth unless the client has employed a midwife or medical practitioner to provide for her clinical care and that person is either present with the laboring woman or has asked the woman to labor alone.<sup>11</sup>*

There have been many reports recently of an increase in freebirths<sup>12</sup> and also an increase in freebirths attended by doulas. The incidence of this is likely to skyrocket with the implementation of the National Regulation process and the exclusion of homebirth from the government's indemnity subsidy. Exclusion of homebirth care from Medicare funding is also likely to mean the continuation of the rise in freebirth or doula attended births for economic reasons. Many women are now perceiving that a less expensive doula is an adequate support for birth in the home. They see a doula as a person who has *some idea* of what is happening through the birthing process. Women may mistakenly view this as "safer" although doulas are not trained to resuscitate mothers or babies, detect complexities or treat them, or to know when there is a need for transfer. In some ways this presents a picture that is even less safe than free-birthing without a doula because women may mistakenly believe that the doula will keep them from harm.

From July 2010 under proposed legislation women will have great difficulty in finding a private midwife who is registered and who is prepared to attend them for birth in the home. This legislation is likely to force many current midwives in private practice from the workforce altogether, as working in hospital is not seen as a viable option for these midwives because the fragmented systems of care directly contradict their philosophy of birth and supporting women's choices. This is contrary to the stated position of the government who clearly, with the reform process it has begun, would like to see the expansion of private midwifery services in Australia. There is already a shortage of private practice midwives in Queensland, particularly in western and northern areas where there is a complete lack of private midwifery care. This lack of choice drives women to birth at home unattended or with an unregistered practitioner.

Recently there have been two cases where women have decided to "freebirth" after previous caesarean sections because they have been unsupported by hospital policy and have been unable to find a private midwife locally to provide care. In both situations, one in NSW and one in Far North Queensland, doulas were in attendance, the women both ruptured their uterus which is a rare occurrence during the normal process of labour, undetected by the doulas, and both of the babies died. In the case in Far North Queensland the woman also required a hysterectomy as a life-saving measure to stop internal haemorrhage.

Regular monitoring by a midwife may have detected problems prior to a uterine rupture. There are very clear signs for midwives when problems occur, such as alterations in the baby's heartbeat in utero, changes in the mother's vital signs and pain and increase in blood loss. These recent deaths highlight failure within the maternity care system to respond to the needs of women. They also indicate that women will seek the type of care they desire and that changes must occur in the system to ensure that all women have safe options available.

Women at all levels of risk need to have options for care and access to midwives for primary care. Some will also need differing levels of consultation with other care providers but a known midwife can still provide the midwifery component of care.

## **Proposed model of homebirth care**

Midwives in private practice should be provided both funding and indemnity under Federal government reforms. Midwives would practice according to the ACM guidelines, which clearly state when consultation and referral are required, however, the guidelines are underpinned by the understanding that women have the right to informed consent *and* informed refusal. Mechanisms must be in place to ensure that midwives caring for women who take up the right of refusal are protected from regulatory action, and that women have adequate education and information to make appropriate decisions regarding their care.

Midwives providing care for homebirth would fulfil the requirements for eligibility set down by the profession. This is expected to be a credentialing process (Midwifery Practice Review), demonstration of continuing professional development (MidPLUS) and current registration (including indemnity when available). Midwives providing homebirth care would be working in a model where they have visiting rights to a local hospital and can freely consult and refer with other practitioners as required. A further requirement likely to be a component of such a model is that two midwives attend all births in the home.

## **Conclusion**

The private midwifery model is not utilised effectively in Australia leaving women with a limited range of maternity care options. The combination of Health Practitioner National Regulation legislation and the currently proposed Federal maternity reform package (3 bills) will leave Queensland women without the option of having a registered midwife provide them with homebirth care. Midwives are specialists in normal pregnancy and birth and are educated and regulated to provide the full spectrum of care for women, including referral to other professionals when deviations from normal occur during pregnancy, birth or after birth. State based models will only provide a small number of programs in limited areas, likely to be large cities. Private practice midwives predominantly provide homebirth care. Restricting this option will limit the ability for women to access safe care in the home. This is not acceptable in a democratic society which places great value on public safety in health care.

## **REFERENCES**

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