

BirthMatters

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Spring 2011

LABOUR AND BIRTH ISSUE



This issue:

MC response to ACM interim homebirth position statement and guidelines

PLUS:

Roz Donnellan-Fernandez on the benefits of birthing in water



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Coalition

Our vision: Every woman can choose how, where and with whom she births

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Advertising bookings must be received by the 1st of the month prior to publication and ads must be received by the 15th of the month prior to publication.

Would you like to write for *Birth Matters*?

Members of Maternity Coalition and writers for *Birth Matters* come from diverse backgrounds, ranging from seasoned birth activists, to others who have only recently started thinking about maternity, perhaps with the birth of their first child. Some are midwives, some doctors, some have academic positions unrelated to health, some are in business, and others have no professional qualification but all have something important to say about maternity care in Australia.

All material submitted for publication is considered by the editing team in relation to its contribution to maternity reform. Birth stories are always welcome as first-person accounts of contemporary Australian birth experiences.

Submissions should be no more than 2500 words in length as a general rule and photos accompanying birth stories must be high resolution (300dpi or higher).

Birth Matters offers a personal voice that is not commonly heard in maternity, and other health-related discussions. If you believe you have something to say or an experience to share, please contact us by email, post or telephone.

The *Birth Matters* Editorial Team
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Main Cover Photo: Baby Bodhi Evans makes a stunning entrance. Photo courtesy of mum Emily Gill and Milk Photography, Melbourne www.milkphotography.com.au.

From the Editor



It's been a rough six months.

In April this year we left Darwin, our home of almost 13 years, and moved to Canberra. Paul was excited (a new, more challenging position awaited him). Me, not so much. During the decision-making phase of the operation, I compiled a long list of the reasons I didn't want to go. Somewhere near the top was the fact that I would be leaving the house in which I had raised my first child from the age of 10 months and given birth to my subsequent two.

It was on the shady verandah of that house that Gabe and I sat each sweltering afternoon, the hose running up from the garden to fill his clam-shaped baby pool, while we waited for the storm that would never come and his father to get home from work. It was in the kitchen of that house that we made bright green play dough and on the back lawn that I used it to model the most realistic crocodile EVER. In the park out back of that house Gabe kicked his first footy, took his first mark, learned to ride without training wheels and, with the Campbell boys from down the street, spent countless shirtless arvos playing cricket and tip and climbing the mango trees.

It was into that lounge room, in the spot between the bookshelf and the kitchen, that Daniel was born and, not quite two days later, left as quietly and as gently as he'd come. And into that same little space, three years later almost to the day, his beautiful sister came. I walked those polished wooden floorboards with all my babes on the nights when teeth or the heat or the thunder or the green tree frog chorus wouldn't let sleep come.

In the time leading up to our departure I must have heard every relocation-related platitude a thousand times – it's just a house ... home is where the heart is ... you can take your memories with you ... you can always come back. All of this was true. But it was still a wrench.

I kept my promise not to be imprisoned by the cold, to "just rug up and get out in it." I braved the bleakest day of the year to stand on Gabe's school oval and cheer him through the annual cross-country selections. I fronted at footy every Saturday morning, even when the mercury failed to creep above zero. I tried – really and truly I did – to take Saffy to the park at least every second day (don't even get me started on the fun I had rugging up a nine month old whose life to that point had been lived almost entirely in the nude) and to hang around the school quadrangle during even the iciest of morning assemblies to meet other parents. I even took Gabe outdoor ice skating (how's that for embracing the experience). None of it was easy.

But the weather, as hard as it was to hack, was only part of the problem. More than the heat or the northern lifestyle I missed the strong, supportive networks it had taken me years to build – mostly through the shared experiences of pregnancy, birth and mothering – and the women who had stuck by me through some of the best and most trying times of my life. I felt lonely, disconnected. And though I reminded myself regularly that, in the bigger scheme of things, my problems were incredibly minor and that I was extraordinarily fortunate in so very many ways, it didn't stop me wallowing.

One thing that did help me to feel 'connected' was my involvement with MC. Though I have met few of my fellow management committee members in person and we converse only via email or Skype, there is a definite sense of community that comes with knowing that as I try to edit Birth Matters with Saffy on one knee or stay up late proofreading submissions or catching up on emails, there are other women all over Australia juggling babies, children, families, and careers to fulfil their commitment to MC and what it represents. It feels good to know that so many of us out there are chasing the same goal and that none of us is alone, regardless of our individual circumstances.

Following my own recent experience, two of this issue's stories have particular resonance for me. The first is our anonymous contribution on page 15, which details the lasting impact of a

traumatic hospital birth on one woman and her family. The second is the story of the birthing women of Bourke (page 18) who, two years after the 'temporary' closure of their local birthing unit, are still being forced to travel hundreds of kilometres to birth their babies far from family and known carers. The women in these stories have experienced isolation and loneliness during pregnancy, birth and their first days and weeks of mothering due to circumstances not of their choosing, and they are the very reason MC exists.

The absence of stomping, shouting and rallying of late has, I think, led many to believe that there's very little doing in the world of maternity reform. Certainly some of the articles in this issue depict a process that is very much 'one step forward, two steps back' and reflect women's frustration at the continued lack of choice. Despite the relative quiet, MC continues to push for improved information, access and choice for all women, as evidenced by our comprehensive submission to the Australian College of Midwives regarding the recently released Interim Position Statement on Homebirth and Interim Guidance to Privately Practising midwives providing midwifery care for a planned homebirth. Other recent developments are summarised in our federal update on page 5.

In the first of two features on 'collaborative arrangements', women describe the impact this requirement is having on their ability to access Medicare-rebateable midwifery care and detail some of the specific obstacles in their way. A second article based on the experiences of privately practising midwives throughout Australia will follow in our December edition.

Meanwhile, spring has finally sprung (well, more like hobbled or limped if I'm honest) in the nation's capital and new life abounds. It's hard to stay down with all these flowers and green things around me. My lovely mate and fellow Darwin MC-er Sam Phelan always tells me that maternity reform is a marathon and not a sprint (I'm trying to look at my Canberra adventure the same way). As a relative newbie to the movement, I don't reckon I've yet earned the right to be hitting the wall, so I s'pose I'll just keep going. I know that so many others are running the same race and that many are doing it way tougher than I am. It helps to have such great company on the road.

Kylie Sheffield

From the Vice President



Ann Catchlove

This month's *Birth Matters* theme is a timely one. We have seen in recent months many issues around intrapartum care. The maternity reforms that were supposed to provide a greater range of women with the option of having their own midwife for hospital birth have met major hurdles when it comes to actually having your midwife provide care at the birth. The exemption from the requirement for privately practising midwives to have insurance for intrapartum homebirth care has been extended from July 2012 to July 2013. This provides some much needed breathing space but there remains no clear solution for what should happen next. Questions have recently been raised about the ability of midwives attending homebirths to transfer their clients to hospital when needed (they can) and the role of the privately practising midwife who stays with her client during a hospital birth (she can, but only in a support role).

The Australian College of Midwives (ACM) "Interim Position Statement on Homebirth" has caused major alarm, setting out a number of situations where homebirth cannot be supported with midwifery care. The position statement (and accompanying guidance to midwives) raises many issues around whether women are able to have the carer of their choice with them during labour and birth when they do not follow advice or recommendations and the obligations of midwives in caring for these women. Maternity Coalition (MC) is concerned that the document essentially advocates midwives abandoning women who make certain choices. You can read MC's full response to the position statement on page ...

It seems to be very difficult for policy makers, regulators and even some midwives to understand why having the carer of your choice at the birth place of your choice is so important to women.

It is during labour and birth that continuity of carer really comes into its own. Having the same caregiver

throughout the antenatal period is of course important for the quality of your antenatal care, but for me, the real strength is the relationship that is developed for your intrapartum care. When women talk about wanting continuity of carer, that is what is important to them – knowing and trusting the person who is going to provide care, advice and support when they are actually in labour.

I have come at this from all sides now. For my first pregnancy I knew that I wanted continuity of care but I didn't understand how things worked. I chose a private obstetrician so that I would have a consistent care provider throughout my pregnancy and so that I would know the person who would be caring for me when I had my baby. I didn't twig that I would arrive in hospital at a time of great vulnerability and be landed with a midwife who I had never laid eyes on before. I didn't realise that five-minute antenatal appointments do not allow you to develop a relationship of trust with your care provider so that you can feel confident that you are making the right decisions for you and your baby.

For my second pregnancy I knew I wanted something different. I knew that I needed the support of a known and trusted caregiver who would support me to have the birth I wanted. I knew I wanted continuity of midwifery care. I was pretty sure I wanted to birth in a hospital or birth centre. However, as I was now planning a VBAC, it was pretty much impossible to have all my wishes met. So (to no-one's greater surprise than my own) I found myself planning a homebirth. My son's birth was literally a life-changing experience.

When I fell pregnant for the third time there was no question that I was signing up for another beautiful homebirth. Sadly, my daughter had other plans and I ended up with another emergency C-section.

It was during this birth that I really needed my midwives. They were

wonderful during the joyful occasion of my son's birth but I simply could not have had the birth I did this last time without them. It was my midwife who came to me in the early hours of the morning, even though I didn't appear to be in established labour, because she knew me and she knew I seemed to be in a lot of pain despite having fairly short and irregular contractions. It was my midwife who knew when we needed to change our plans. It was because both of my midwives were with us in hospital that I was able to be confident and strong in negotiating what I wanted for the birth. It was my midwife who held my hand during the surgery. The presence of my midwives helped to make sure that my daughter and I were never separated. It was my midwives who listened in the days and weeks afterwards as I tried to make sense of what had happened.

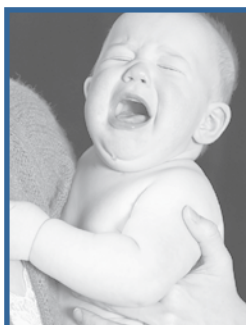
I cannot imagine what might have transpired if I had chosen another model of care. The outcome on paper probably would have been the same but the difference in terms of those things that aren't measured would have been immense.

That difference is why I am involved in MC and why I want all women to have access to true continuity of care regardless of their risk status and regardless of where they birth. It is disheartening that so few decision makers get it, but essential that we keep on working towards that goal.

Ann Catchlove

Is your membership up to date?

**Renew today.
See page 32**



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About Alecia

By Alecia Staines



Stepping into the energetic and capable shoes of Bec Jenkinson as she prepares to welcome her third babe, incoming MC Queensland president Alecia Staines shares a bit about herself and what motivated her to become involved with MC.

I grew up in a very small rural community on the Darling Downs called "The Gums", which led to my keen interest in agriculture and rural issues, a successful career as a high school agriculture teacher and my work promoting the agribusiness sector to raise the profile and reputation of our primary producers. Since having children, I have developed a keen interest in improving maternity services in rural areas, and particularly the need for continuity of care models throughout the state.

My first son Lawson was born in 2009 under the Goondiwindi

Midwifery Group Practice. I had such supportive known midwives all through my pregnancy and birth, and came away from my birthing experience feeling both empowered and positive.

My daughter Tully was born in Toowoomba Base Hospital earlier this year, during a brief stint away from

Goondiwindi, and I was cared for by Liz Wilkes from My Midwives. Again, having such a wonderful trusting relationship with my midwife made my birthing experience a memorable one for all the right reasons.

I have since moved back to Goondiwindi and am a single mum, raising my two children. I'm still keenly involved in education, agriculture, community and rural maternity services.

Some of the MC items on my agenda are the Normal Birth Guidelines, Continuity of Care mentoring program, Consumer Representative training, talking to rural midwives and encouraging and supporting them with continuity of care midwifery, supporting MC Darling Downs, speaking at the ACM state conference in Brisbane with Alison Gaffney and checking the president's email!

I've taken over the QLD presidency from Bec Jenkinson, who's ready to have her baby anytime now [see *postscript to Bec's story on page 11*] and I thank her immensely for the commitment and hours she dedicates to MC for the greater good of birthing mothers. I am sure she will be back on deck in no time. I wish her all the best with her birth and hope she enjoys baby number three.

ARTICLE SUBMISSIONS DEADLINE: FRIDAY 28TH OCTOBER

Summer Theme – Postnatal Care and Annual Report Edition

- MC Annual Report
- State and branch reports
- A look back at the year that was
- Postnatal care – why is it so important?

Deadline: Friday 28th October

IMPORTANT: We'd love the summer edition to make it out to you before Christmas so please make the deadline.

Articles should be a maximum of 3000 words and be accompanied by photos where possible. Please email submissions to birthmatters@maternitycoalition.org.au on or before the posted deadlines.

Federal update

By Kylie Sheffield

Australian College of Midwives Interim Position Statement on Homebirth and Interim Guidance to Privately Practising Midwives Providing Midwifery Care for a Planned Homebirth

In May this year, Maternity Coalition (MC) was asked to provide feedback on the Australian College of Midwives (ACM) draft *Position Statement on Homebirth*. MC's response was summarised under the federal update in the winter edition of *Birth Matters*.

An amended version of the original draft – including an additional section entitled *Guidance for privately practising midwives providing midwifery care for a planned homebirth* – was endorsed by the Nursing and Midwifery Board of Australia (NMBA) in June and can be found on the NMBA website at: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Position-Statements.aspx>.

In August the ACM released, via its website, an *Interim Position Statement on Homebirth, Interim Guidance for Privately Practising Midwives Providing Midwifery Care for a Planned Homebirth and a Homebirth Literature Review*. Acknowledging that the original position statement was developed with “targeted consultation [and] within limited timeframes,” ACM sought broader stakeholder input on the interim documents by 23 September 2011.

As clarified by the NMBA in a letter to stakeholders on 31 August “...it is anticipated that the ACM will present the Board with a revised *Position Statement on Homebirth* for endorsement and subsequent rescinding of the existing Board endorsed.”

ACM Executive Officer Ann Kinnear has confirmed to MC that submissions received in response to the current call for feedback will be collated and a review panel formed. The panel will consist of an ACM representative from each ACM Branch and two consumer representatives (nominated by the ACM Consumer Advisory Committee), who will meet in October to consider the feedback and provide advice to the ACM National Board of Directors. Once endorsed by the ACM National Board of Directors, the information will be published on the ACM website.

MC's full response to the interim documents is included on page 7.

PII and transfer to a public health service

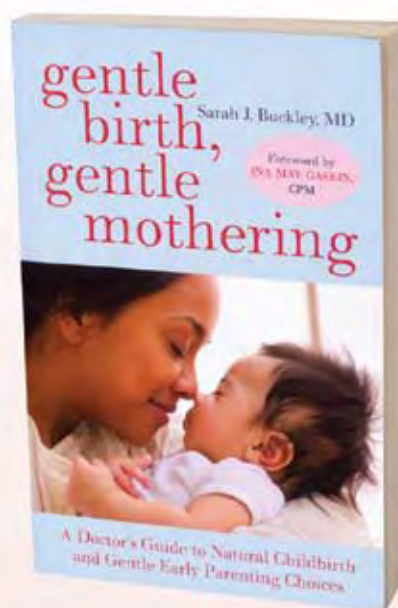
Since 1 November 2010 all midwives practising in Australia have been required under the National Health Practitioner Regulation law to hold professional indemnity insurance (PII). An exemption currently applies to midwives attending labour and birth at home, specifically for the intrapartum component of their care. While midwives employed by hospitals are covered by their employer, privately practising midwives (PPMs) must purchase insurance through MIGA (Commonwealth-subsidised) or

Mediprotect. These policies do not cover midwives for the care of public patients.

In August 2011 an incident involving a PPM and the staff of a public maternity unit sparked concerns that MIGA defined any interaction between a midwife and her client as ‘midwifery care’ requiring insurance. This included the offering of advice or any form of physical or emotional support during labour and birth once responsibility for the woman's care had officially been transferred to the public facility. There was also a concern that midwives were unable to transfer a client to a public hospital during the course of a planned homebirth without breaching the requirements of the legislation.

‘Sarah J. Buckley’s book is hands-down and easily the best of all birthing books yet.’

Joseph Chilton Pearce, author of *Magical Parent Magical Child*



‘Sarah Buckley’s work is unique: as a health professional AND a hands-on mother, Sarah exquisitely demonstrates how science affirms the intuitive wisdom of motherlove as well as how gentle parenting works in practice — not just in theory.’

Pinky McKay, author of *Parenting by Heart* and *100 Ways to Calm the Crying*, Melbourne

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On 25 August press releases on the issue from the Australian Private Midwives Association and ACM were picked up by three major newspapers, further fuelling speculation that midwives would be required to “abandon women at the door” and risk deregistration should they offer any form of comfort or support once inside the hospital.

On 2 September the NMBA released a statement entitled *Role of the registered midwife in private practice when the woman is admitted to a health service as a public patient*, which clarified the Board’s position in relation to the following key points.

- When a woman being cared for by a PPM must be admitted to a public health service, it is the responsibility of the midwife to ensure safe transfer and provide a comprehensive handover.
- Once the woman is admitted to the health service, PII arrangements for the midwife cease.
- The midwife may choose to withdraw once the woman has been transferred but may, at the woman’s request, remain with the woman in a supporting role.
- The midwife must communicate her change in role to the woman and the health service, and the woman must consent to the midwife’s involvement as a support person only.

- The Board defines the role of the support person as providing “the type of emotional and practical support reasonably expected by any lay person.”
- The Board would not consider a midwife providing this type of support to be in breach of the PII registration standard.

The full position statement is available at <http://www.nursingmidwiferyboard.gov.au/News/2011-09-02-Position-statement-on-midwives-in-private-practice.aspx>.

Homebirth – where are we now?

Insurance exemption

In August 2011 the Government extended the initial two-year insurance exemption for PPMs providing attending homebirths to 1 July 2013. This means that midwives can continue to offer intrapartum care to women at home, provided they:

- report all homebirths according to the requirements of their jurisdiction,
- advise clients in writing that they are practising without insurance for the intrapartum component of their care, and
- participate in the NMBA-endorsed Safety and Quality Framework for midwifery care (<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx>).

Medicare and collaborative arrangements

A midwife attending homebirths can choose to become an ‘eligible midwife’, enabling her to access the Commonwealth-subsidised MIGA insurance product and allowing her clients to receive Medicare benefits for antenatal and postnatal care. To meet eligibility requirements, a midwife must enter into a collaborative arrangement with an obstetrician or GP obstetrician (see article page 11). The collaboration requirement does not apply to midwives who do not wish to provide Medicare-rebateable services or who choose to be insured by Mediprotect.

What about women who don’t fit the ‘low-risk’ criteria?

The general confusion around who ‘can’ have a homebirth is largely a result of the ambiguous and contradictory nature of the documents produced to clarify the issue. The fact is that any woman, regardless of perceived risk factors, has the right to choose where and with whom she births. Whether she can find an accessible midwife to support her in this choice is a different matter.

In further engaging policy makers, MC will continue to emphasise the need for guiding documents to respect women’s decision-making autonomy and right of informed refusal, and clearly acknowledge the duty of care of the midwife in not abandoning a woman should her choices not accord with clinical advice or professional guidelines.

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Maternity Coalition feedback on Australian College of Midwives statements

Maternity Coalition feedback on the Australian College of Midwives Interim Position Statement on Homebirth and Interim Guidance to Privately Practising Midwives providing midwifery care for a planned homebirth

Maternity Coalition (MC) welcomes the release of the above documents for broad public consultation.

MC hopes that the public release of the documents represents a commitment from the Australian College of Midwives (ACM) to work closely with consumers to develop a position statement that addresses the very real concerns of women and protects the midwives who care for them. We understand that a process has been put in place to review the documents and that consumers will be represented on that. MC looks forward to being a part of this process.

It must be acknowledged at the outset that the content of these interim documents has caused serious distress to many women (particularly those who are currently pregnant) who have feared that their choice to have a homebirth has been removed and that they will be abandoned in their care because of the choices that they have made.

As detailed in our submission in relation to the draft homebirth position statement we held significant concerns about the development and consultation process for that document. We note that the "Interim Guidance to Privately Practising Midwives" (the Guidance) was not included in the documents released for the earlier "targeted" consultation even though it is significantly more restrictive than the document that was released. It appears that this document has extracted some of the previous position statement and added a number of additional elements that were not subject to consultation.

Overall, we consider that the Guidance documents, as currently worded, put women at risk of coercion and put midwives at risk of breaching their legal and professional responsibilities.

Summary of MC's position

Maternity Coalition considers these to be the key points regarding midwifery care for homebirth:

- Some women choose to birth at home and many will continue to make that choice even if it is not possible to have a registered midwife in attendance. Some women will choose unregistered birth attendants if registered practitioners are inaccessible or unable to provide care.
- Women have the legal right to choose where they will give birth. The law and midwifery professional guidance supports women's autonomy during pregnancy and birth and women's right to make decisions about their options at this time.
- Women should have access to evidence-based information and expert professional advice on the potential risks and benefits of the various choices of birth place and care.
- It is essential that women have access to skilled care wherever they give birth, including at home. Processes determining midwifery practice (including legislative, regulatory, professional and insurance) must protect the safety of women and children by ensuring that midwives can provide care when and where women give birth.
- Women should not be abandoned by their care providers (or threatened with abandonment) as a result of the decisions that they make, or in order to coerce them to make particular choices, in any care setting.
- Evidence supports the safety of homebirth for "low risk" women. There is a lack of evidence on the safety of homebirth for women who are not perceived to be "low risk".
- According to the International Confederation of Midwives (ICM) definition of the midwife, midwives are able to provide birth care at home.
- In Australia there is a framework of guidance and regulation for midwifery practice which applies to birth in all settings. This includes the Australian College of Midwives Guidelines for Consultation and Referral which provide guidance to midwives on when women should be advised to access medical care and how to proceed when women refuse that advice.
- It is part of the midwife's role to use her professional judgement to make clinical decisions about each

woman's care, taking her unique circumstances into consideration, as well as midwifery professional guidance.

- There is no legal or regulatory impediment to the ACM developing clear and unambiguous guidelines protecting midwives who respect women's informed decisions to birth at home.
- Recognition of women's rights to informed consent and refusal is meaningless in a context where women will be denied care if they make particular choices.
- The failure of the documents to comprehensively and realistically address women's right to informed refusal puts women and the midwives who attend them in a precarious situation and should be remedied.

Women's decision making

The ACM, the Nursing and Midwifery Board of Australia (NMBA) and governments at all levels must recognise that some women will continue to make the decision to birth at home irrespective of the legislative or regulatory framework surrounding midwifery practice. Policies and guidelines which discourage midwives from supporting certain women in their choice to homebirth will not necessarily lead to those women instead making a decision to birth in hospital settings. MC submits that a number of women who would otherwise choose to have a registered midwife present at their birth will instead choose to birth unassisted or with unregistered attendants. Such an outcome surely runs contrary to the intention of the national registration scheme and undermines the role of the midwife.

We must also acknowledge the context within which women are making decisions about place of birth. This includes a woman's personal context (for example previous traumatic experiences with hospital) and the systemic context. We do not currently have a maternity system where women's choices are universally respected and accommodated. If women could access the degree of choice and autonomy that they have at home in a hospital setting there would be less of an issue around birthing at home against medical advice. In most cases they cannot. Women wanting to have a physiological

birth without intervention for a VBAC, breech or twin birth will often find that very difficult to access in hospital. The ACM must not remove women's access to some choices when the alternatives do not meet their needs.

Midwifery leaders and regulators have a choice about whether they want to see homebirth sit within the regulatory framework of midwifery registration or whether it instead becomes the domain of unregistered and potentially unqualified care providers. If we want to keep the protections to the public that come from registration then we need to respect that women will sometimes make choices against advice or guidelines and allow for midwives to provide care at home when that takes place.

How do the interim documents address the midwife's role in women's decision making?

MC submits that it is essential that two interconnected principles be at the centre of any position statement, policy or guideline regarding homebirth. The first is the right of consumers to make decisions regarding place of birth, including the right to make decisions that do not accord with the document in question. The second is the midwife's obligation to respect women's decision-making autonomy and to provide that women need not be abandoned because of the choices they make.

The interim position statement (the "position statement") and the Interim Guidance for Privately Practising Midwives Providing Midwifery Care for a Planned Homebirth (the "Guidance") present an unclear and contradictory position on these principles. The position statement starts with a strong exposition of women's right to choose where and how they wish to give birth. It then goes on to detail that it is the position of the ACM that "home is an appropriate place of birth for women considered to be at low obstetric risk". Most of the document then deals with the evidence justifying why home is an appropriate place of birth for such women. The position statement is however silent on the gap between a woman's right to choose and what should happen if she is not considered to be of "low obstetric risk".

The Guidance makes a range of contradictory attempts to address this gap. It presents a very vague, grammatically incorrect and paternalistic discussion under the subheading "Client evaluation for homebirth" about how a woman's suitability for homebirth is to be determined. It appears to identify that only compliant women should be considered suitable for homebirth and not those who lack the "motivation to cooperate with

agreed care". This whole section should be reworded.

The Guidance then identifies a number of contraindications to a planned homebirth that women should be informed about at booking. The Guidance appears to neglect that it is not within its scope to tell women where they may or may not plan to give birth, and we presume the intention is to advise women in which circumstances they may receive midwifery care. Depending on the timing of booking it is likely that only one of these contraindications, having a "scarred uterus", will already be evident. Contraindication is a word not previously used in the documentation regarding homebirth produced by either the ACM

“

Women should not be abandoned by their care providers (or threatened with abandonment) as a result of the decisions that they make, or in order to coerce them to make particular choices, in any care setting.

or the NMBA. It is used in the South Australian policy for their publicly funded homebirth program. The meaning of the word "contraindication" is not equivocal. There is no discretion allowed for, it clearly means that a homebirth in these situations may not be supported with midwifery care. Therefore a woman wanting to have a VBAC at home must be told at the outset that the midwife cannot provide care. A woman must also be told that midwives cannot provide homebirth care in the case of multiple pregnancy, abnormal presentation, preterm labour and post term pregnancy.

The issue arises again in the section titled "Informed Choice and the provision of information" which is the most confused and contradictory section of the Guidance. This section begins with a reasonably clear acknowledgment of women's rights to make decisions about place of birth including the right of refusal (although this right is incorrectly worded as the "right to refuse care" rather than the right to refuse a suggested course of action).

The section then includes a paragraph that significantly undermines the rights detailed above by providing that a midwife must advise a woman of situations where homebirth "cannot be supported". This is a clear and unequivocal statement

that a woman should be told she cannot be supported if she makes particular decisions. It is simply not possible for a woman to have "autonomy and control" and to be provided with information "without coercion" when she is being told that if she makes a particular choice she cannot be supported.

It then goes on to say that "at any time" a midwife is not obliged to participate in a homebirth that the midwife considers will increase the risk of harm to a woman or her baby. This sentence clearly contradicts the well documented professional and legal duty of the midwife to provide care during labour and birth or an emergency situation (which is clearly stated in the position statement itself). In these situations a midwife is obliged to "participate" even if she is not personally comfortable with what is taking place. ACM's Consultation and Referral Guidelines make this very clear. A midwife who abandoned a client during labour would also be in breach of her common law duty of care to her client. It seems that underlying this statement is a fear that midwives might be put in a situation where they are forced to agree to support women at other times. MC submits that there is a vast gulf between protecting a midwife who chooses to support a woman's informed choices and compelling a midwife to do so. It is very simple to draft a document that does one but not the other.

A key reason why the provisions in the interim documents relating to informed choice for women are unclear and contradictory is that they confuse the roles of the woman and the midwife in the decision-making process. The midwife's role is to give advice; the woman's is to make decisions after considering the advice given. The United Kingdom Nursing and Midwifery Council's document "Supporting women in their choice for home birth" manages this distinction well. The discussion around suitability for homebirth under the subheading "Assessment for homebirth" states:

Women should be offered the choice of planning birth at home and it is a midwife's duty to make all options, benefits or risks clear and to facilitate and respect the choices a woman makes if she has the capacity to make that choice. The woman may need to reassess the choice she has made if the midwife identifies, at an assessment, any risk factors and/or conditions during the pregnancy that would suggest a planned birth in an obstetric unit is more appropriate. The midwife should document the options, benefits and risks and any discussions and advice she has given to the woman in the hand-held maternity notes.

Conflict sometimes arises over whether or not the woman is making a choice that places her or her unborn child at risk. Any risks and the additional care that can be provided in the obstetric unit should be discussed with the woman using best available evidence so that she can make an informed choice about place of birth. In assessing where a woman is best advised to give birth, the midwife should also give consideration to the woman's physical and mental health as well as factors pertinent to her individual and unique situation.

The midwife offers information about the benefits and risks of various options, assesses risk factors and gives advice about place of birth using the best available evidence. The woman makes choices and may need to reassess those choices as the pregnancy progresses. The midwife does not make choices for the woman. Both the woman and the midwife operate in a context where "it is important to:

- respect and support a woman's rights to accept or decline treatment and care
- uphold a woman's rights to be fully involved in decisions about their care".

The position statement and Guidance should be redrafted so that the distinction between the roles of the midwife and the woman are clarified in accordance with existing professional codes and guidelines.

What do existing Australian professional codes and guidelines say about respect for women's decisions?

Much is made in the professional codes and guidelines surrounding midwifery practice in Australia of the value that midwives place on informed choice and informed decision making. The various documents make clear that it is a midwife's role to provide advice and to respect that women make decisions.

The Code of Ethics for Midwives states that "midwives value informed decision making" and that "midwives recognise the validity of the woman's knowledge of self during pregnancy, labour, birth and early parenting and the need for each woman to have freedom to make choices about her care, informed decision making, and a trusting, supportive and protective environment".

The Code of Professional Conduct for Midwives states that "midwives focus on a woman's health needs, her expectations and aspirations, supporting the informed decision making of each woman". Midwives support informed decision making by "advising the woman and, where the woman wishes, her partner, family, friends or health interpreter, of the nature and purpose of the midwifery care, and assist the woman to make informed decisions about that care."

The National Competency Standards for the Midwife make a number of references to choice. They state that the midwife "has an important advocacy role in protecting the rights of women, families and communities whilst respecting and supporting their right to self determination". Further, midwifery care "recognises the woman's right to self determination in terms of choice, control and continuity of care". The midwife "explains options while recognising the woman's right to choose".

The Australian College of Midwives Guidelines for Consultation and Referral play an influential role in determining midwifery practice in a range of settings.

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Recognition of women's rights to informed consent and refusal is meaningless in a context where women will be denied care if they make particular choices.

The guidelines have a disclaimer at the beginning that they are not prescriptive and "should in no way be interpreted and /or be used as a substitute for an individual midwife's decision making and judgment in situations where care has been negotiated within the context of informed decision making by the individual woman". Despite this disclaimer they are regularly used as a checklist prescribing women's decision making rather than a tool guiding the advice given and action taken by midwives.

The consultation and referral guidelines state that:

Midwifery care must be provided within the principle of informed choice. The midwife must provide the woman with sufficient information to inform the woman's consent to any procedure or advice. The woman has the right to give or refuse consent to any procedure or advice.

They also provide that:

When a woman's choice is significantly at variance from professional advice or guidelines, the woman's decision and the information provided by the midwife should be carefully documented. In these circumstances Appendix A: "When a woman chooses care outside the recommendations of the ACM Guidelines" provides guidance

to the midwife, and a standardised consent form.

The Safety and Quality Framework (the framework) will, according to the NMBA's website, "continue to be used in all future policy documents relating to midwifery". The framework:

Recognises that women will make the final choice about their care and birthing choices in most circumstances. It is incumbent upon PPMs to provide balanced and contemporary clinical advice to ensure that informed decisions are able to be made.

The framework states that women "with a singleton pregnancy, cephalic presentation, at term and free from any significant pre existing medical or pregnancy complications are those identified in the ACM guidelines as clearly meeting criteria for midwifery led care." It does not however identify that only those women can access midwifery led care, and specifically addresses the situation where privately practising midwives are providing homebirth care to women falling outside of those criteria.

The position statement and Guidance sit at odds with these existing professional documents by actively undermining the ability of midwives to support women's informed decision making. A clear statement protecting midwives who support women who have made an informed decision to birth at home contrary to advice or guidelines would fit within the obligations and duties set out in the above documents.

Women's decision making and the law

Women have the right to make their own decisions about their maternity care – who they will have as their carer, where they will give birth and what interventions take place during the birth.

Competent adults have the right to accept or refuse medical treatment. This principle was articulated by Cardozo J in *Schloendorff v. Society of New York Hospital* (1914) 105 NE 92 and quoted in the Australian High Court case of *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218):

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault.

The fact that a woman is carrying a baby has no impact on her legal right to accept or refuse treatment. While there have been no Australian cases on this issue, the UK Court of Appeal has made this very clear in two cases. In *Re MB* [1997] 38 BMLR 175 CA the Court said:

The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though ... the consequence may be the death or serious handicap of the child she bears or her own death ... The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.

In the case of *St George's Health Care NHS Trust v. S, R v. Collins and others ex parte S* [1998] 3 All ER 673 the court held that:

An unborn child, although human and protected by the law in a number of different ways, is not a separate person from its mother. Its need for medical assistance does not prevail over her rights and she is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it.

The law is clear on a woman's rights to refuse medical treatment. This would extend to the right to refuse to attend hospital for intrapartum care no matter what her risk status. The question then turns to whether a midwife who attends such a woman is protected from an action in negligence or disciplinary action if something were to go wrong (whether or not there is a negative outcome).

Significant protection will be afforded to midwives by professional standards and guidelines which clearly and unambiguously recognise that midwives can care for women who choose to birth at home against advice or against guidelines.

If a midwife is reported to the NMBA for unprofessional conduct then the fact that she has followed the process set out in the ACM guidelines or some other guidance document would strongly support her position. If a process for documenting and respecting women's decision making is included in this position statement and Guidance which is then adopted by the NMBA under section 39 of the National Law then it would be admissible in proceedings against a registered midwife as "evidence of what constitutes appropriate professional conduct or practice" for midwives (section 40). This would provide substantial protection to the midwife who ensures her clients make informed decisions and who respects those decisions.

Like other care providers, midwives must present adequate information to enable their clients to make informed decisions. Informed consent respects the decision-making autonomy of women

and protects midwives from litigation. If a woman has been given evidence-based information about the risks involved for her in birthing at home and there is clear documentation of the discussions that have taken place in coming to a decision about place of birth, then a midwife is well protected. The High Court in the case of *Rogers v Whittaker* (1992) 175 CLR 479 referred to "the paramount consideration that a person is entitled to make his own decisions about his life" and found that:

The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

Good documentation of women's decision-making processes is necessary and guidance should be given to midwives on how to do this. A process for dealing with the situation of a woman choosing care outside of recommendations is contained in the ACM's National Midwifery Guidelines for Consultation and Referral. The ACM guidelines are not about place of birth and the position statement and Guidance document should clearly provide that Appendix A can also apply to women planning homebirth.

Duty of care protection

There is much confusion in Australia around the idea of "duty of care" protection for midwives. It is often suggested that midwives have no protection in the case of providing care outside of professional guidelines because Australia does not have the duty of care legislation for midwives that exists in the United Kingdom. However there is actually no such legislation in the United Kingdom. As in Australia the issue is covered by a mix of common law and professional guidance. The ACM and regulators have an opportunity with these interim documents to clearly state the professional obligations of midwives in this area and to clarify the position for women and midwives. If this opportunity is not taken up we will be in a situation of greater confusion than ever before with midwives who support women's decision making being at high risk of having disciplinary action taken against them, and midwives who withdraw care being at risk of legal actions under the common law.

Midwives do have a common law duty of care towards their clients. A duty of care under common law has no less weight

than a legislative duty of care would. The ACM should be extremely cautious when making a general statement that at any time a midwife is not obliged to participate in a homebirth where they consider it will increase the risk of harm to a woman or her baby. Following this statement would place midwives in a vulnerable legal position. It is generally recognised that a midwife who left a client during labour or who refused to attend a current client during labour would be at risk of breaching her duty of care to that client. How far this duty extends is unclear but a midwife would be well advised to seek advice before abandoning a client to birth without professional care.

Scope of practice

It is our understanding that some concerns about midwives providing homebirth care to women with risk factors relate to scope of midwifery practice. MC submits that there is no guidance or regulation in Australia which circumscribes a scope of midwifery practice, or which restricts a midwife's ability to provide care to women with risk factors or complex needs. Indeed a high proportion of midwives' daily practice is providing care to women with complex needs. While many of these women will be under medical care in addition to midwifery care, and doctors may be directing care, midwives remain responsible for all care they provide.

The ICM definition of a midwife does not restrict midwifery care to the "normal". The ACM Guidelines specifically instruct midwives on when to consult or refer, and do not describe a scope of practice or instruct when not to provide care. In summary, we believe that there is no restriction to midwives' scope of practice which supports the proposed contraindications in the Guidance, or the advice to midwives to withdraw care.

Conclusion

MC submits that there is no reason why women's right to make informed decisions about their maternity care should be overridden by the position statement and Guidance. The failure of the documents to comprehensively and realistically address women's right to informed refusal puts women and the midwives who attend them in a precarious situation. It should be remedied.

The ACM now has the opportunity to produce a robust and considered position statement on homebirth – a position statement that meets the needs of both women and midwives. We look forward to continuing a dialogue with ACM to ensure that women really are placed at the centre of maternity care and that their rights are respected.

How's *that* working out for you? 'Collaborative arrangements' – the consumer perspective

In November 2009 Federal Health Minister Nicola Roxon announced that the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, which seemed to at last deliver increased choice and improved access in maternity care, would be amended to include the requirement for midwives to hold formal 'collaborative arrangements' with a specified obstetrician or GP obstetrician in order to access a Medicare provider number, pharmaceutical benefits scheme (PBS) prescribing rights and professional indemnity insurance (PII). While peak medical bodies applauded Roxon and pushed collaboration as the only way to ensure safe, "patient-centred" care, midwives and consumer groups labelled the stipulation anti-competitive and warned it would allow obstetricians the power of veto over midwifery practice and inevitably restrict, rather than improve, choice for women.

Despite intense lobbying from midwives and consumers, and following a Senate Committee Inquiry into the proposed amendments, the changes to the Bill were passed the following March and followed in July by National Health (Collaborative arrangements for midwives) Determination 2010, which defined collaborative arrangements as they would apply to midwives wanting to provide Medicare-rebateable services and gain PBS prescribing rights (the PII component of the amendment was dropped). Under the Determination, midwives are required to demonstrate the existence of a formal arrangement with one or more obstetric specialists.

More than a year on, with a handful of notable exceptions, mutually supportive and respectful collaboration is rare, leaving women still unable to affordably access the carer, model of care and birth place of their choice and receive the desired continuity throughout pregnancy, birth and the postnatal period (supposedly the whole point of the reform process). This is the first of two articles on the reality of collaborative arrangements and what they mean for women's choices in pregnancy and birth.

What happens when you ask for a referral?

By Bec Jenkinson, Queensland
The National Health (Collaborative arrangements for midwives) Determination 2010 states that a collaborative arrangement is considered to be in place when "a patient is referred,



Bec Jenkinson with husband Darryl and daughters Indiana and Saffron

in writing, to the midwife for midwifery treatment by a specified medical practitioner." Just how easy is it to get a referral to a private midwife from your friendly local GP obstetrician? When I became pregnant again I decided to find out. The experience left me surprisingly irritated.

My first visit to my GP 'Dr K.' started pleasantly enough. I said I was pregnant again, wanted private midwifery care and asked for a referral. Dr K. replied, "You don't need one." I agreed, but explained that her referral would enable me to access some Medicare rebates. She said that she knew nothing about this and would have to do some research, which, through further discussion, turned out to mean that she wanted to consult her insurer and her college.

When I asked why she believed that referring to a midwife was different to

other referrals she regularly makes, Dr K. explained that her insurer has advised against liaising with "certain nurse practitioners." She said that referral to a specialist obstetrician was quite different because she didn't have to "supervise the care" as she did with nurses. I said a midwife wasn't a nurse and made it clear that I wasn't asking her to supervise, just to refer. I explained that I simply wanted my GP practice to be in the loop. I asked how midwives differed from other non-doctor professionals, such as psychologists and osteopaths (as I've had referrals to both from that practice). She didn't really answer that, but drew comparisons with a woman to whom she had refused a script for syntocinon, requested very late in her pregnancy, on the advice of her insurer. I said I was glad that wasn't what I was asking for, so we didn't need to discuss that situation!

I tried to move the process along by providing the information Dr K. needed to aid her investigation – the name, address and Medicare provider number of my chosen midwife. She said it would take the rest of the week to research the situation and that she would contact me by that Friday.

Thanks very much. That'll be \$50.

The next week, my doctor's practice nurse called to advise me that Dr K. had "declined" to provide my referral as requested. Instead, Dr K. advised me to contact the hospital or an obstetrician. When I asked for a reason, the practice nurse would not elaborate beyond saying,

I was born at home t-shirts for your home born babe

Organic Cotton T-Shirts

All Sizes from newborn up

Baby Suits

Short Sleeve Tees

Long Sleeve Tees

www.birthchoices.info

"Dr K. is not interested in participating." What an interesting phrase! Of course I asked if I could have this advice in writing, which the practice nurse said she would arrange in the next day or so.

When the practice nurse rang back, it was to say that Dr K. would not provide any kind of letter. "She will not collaborate with private midwives." I was told Dr K. does not take any responsibility for care provided by private midwives and does not support homebirth for any of her patients. (This last comment despite the fact that Dr K. had not asked me where I planned to birth – private midwives support women to birth in a range of locations of the woman's choice.) I was told that this was the end of the matter and that she would not be discussing it further.

I apologised to the practice nurse, since she was caught in the middle and I didn't wish to shoot the messenger. I asked her for further clarity about why my doctor would not put her advice in writing for me. She said something about it being Dr K.'s right not to collaborate, which I said that I accepted. I was no longer even asking for a referral, I was simply asking her to give me written advice about refusing the referral. The practice nurse just repeated that it was the end of the matter and Dr K. wasn't interested in discussing it further. I asked her to repeat the exact message from Dr K. so that I could write it down, but she refused, saying it was a busy time for her and that I should call back. She further suggested making an appointment to get the information direct from Dr K. I declined, since I didn't want to pay another \$50 (although the practice nurse indicated that Dr K. would probably bulk bill me). I decided instead to raise the issue when I went back to get my pathology results.

I did finally have my appointment with Dr K. to seek some clarification about why she would neither refer me to a midwife in private practice (MIPP) nor provide a letter of advice relating to her refusal to do so. She explained that her decision was based on advice from her insurer, who directed her to a website. She did tell me the website address, but after several attempts to get her to slowdown enough for me to write it down I gave up – it was somewhere on the Department of Health and Ageing site but I now can't find it. Apparently, that website and Dr K.'s insurer gave her the firm impression that if she collaborated with a MIPP she would need to oversee the care provided. She had therefore decided not to collaborate with any MIPPs, especially ones she didn't know. Apparently she needs to know anyone to whom she refers patients.

Dr K. stated that there was no difference between nurse practitioners and midwives.

Dr K.'s unwillingness to refer me was

further strengthened by the advice from her insurer that it would be unwise to enter into a collaborative arrangement when there were other existing services available to me. She would happily refer me to the birth centre, hospital or obstetrician of my choice, or shared care with her. When I clarified this and specifically said, "So you would support me choosing birth centre care, hospital care, obstetric care or shared care with you; you just wish to veto my choice of private midwifery care?" she agreed with my interpretation.

Dr K. said the only arrangement she would be prepared to accept would be one where I had all my visits with her as well as seeing my midwife. She would need to see me four-weekly, then fortnightly, then weekly. I wasn't sure whether she expected my midwife to come to these visits as well, or simply wanted me to double up on every appointment. When I said that I felt that was over servicing, and placed an unacceptable burden (both in time and money) on me, she was unmoved. I said I was happy to consent for my midwife to share all my information with her via the patient held health record, but she said that she couldn't rely on information provided by a midwife she didn't know. She went to great lengths to state: "I need to take your blood pressure; I need to listen to the baby; I need to ... there are just so many things that can go *wrong* in pregnancy." When I said that the purpose of collaboration was that midwives consult and refer according to their professional guidelines, and asked if she was really stating that she wouldn't be able to accept clinical information (e.g. blood pressure, foetal heart) collected by a midwife, she restated that she needed to know them before she could "oversee their work." She expressed concern that there were no clear rules around requirements for communication etc. and said she felt the situation presented her with an unacceptable medico-legal risk.

Dr K. seemed to be under the impression that my midwife should have been the initiator of the collaborative arrangement, that I had been wrong in asking for a referral. She expressed great concern around the newness of the whole system and her lack of desire to participate in it.

When I queried whether Dr K. felt the same responsibility to oversee the care provided when she referred patients to other non-doctor care providers, for example, psychologists, she said that was "totally different" because in the case of maternity care, there are "two lives at stake" (thus playing the 'someone has the speak for the baby' card). She also said that psychologists are "allied health professionals" while nurse practitioners and midwives are not, and therefore need to be supervised.

Dr K. continued to refuse to provide any written advice to me because I now had a verbal communication from her. She noted that I had taken notes during our conversation and she didn't see any need for a letter.

That was it. I can only begin to imagine how infuriated I would be if I had, in fact, been committed to getting the referral, rather than simply testing the system.

Postscript: We congratulate Bec and Darryl on the birth of Vaughn Reuben Ryan Jenkinson, born at 7.35 am on Wednesday 21 September into Bec's hands (too quick to fill the birth pool in the end) At 9lb 13 oz (4460g) and 56 cm long, Vaughn was born in the caul with his two big sisters looking on in awe – all firsts for Bec, who has promised to send an updated family photo soon.

It worked for me!

By Naomi Homel, New South Wales



This was my second birth, which followed a fantastic birth centre experience with my first son Lewis in 2009 at the Royal Hospital for Women (RHW) in Sydney. I really loved my midwife and wanted her to be involved in my second birth but I also felt really drawn to a homebirth. Tess, my midwife with Lewis, had begun teaming up another midwife Sheryl Sidery, doing a few private homebirths. Sheryl has been a homebirth midwife for many years but also works as a perinatal mental health coordinator at the RHW. I decided to employ Sheryl and Tess as private midwives to care for me during my second pregnancy and to attend my homebirth. My husband and I were really keen on the idea of homebirth and were both well informed about our options (my husband produced a show about birth for *Insight* on SBS a few years ago). The only barrier was the cost. When I became pregnant Sheryl was getting her Medicare provider number sorted out and this was a big selling point for us. We were hopeful that we would be able to recoup some of the cost.

As my pregnancy progressed I kept up my reading on the current developments around private midwives, collaboration and Medicare. Sheryl and I discussed collaboration at one point and, at the time,

she was under the impression that it would not affect us. At around 36 weeks, I read on the MC Facebook page indicating that a collaborative arrangement was required (if we were to receive Medicare benefits), so Sheryl and I both began to look into it further. I was pretty blown away that the information available was so vague and that even Sheryl, who was going through such a rigorous accreditation process, wasn't provided with clear information around what was required.

I spoke to Medicare and also called the government helpline – no one I spoke with had any idea what I was talking about. Through my very good friend Melissa Fox, I got in contact with Bruce Teakle, who was amazing. Bruce outlined the four possible ways for midwives to collaborate (which he also explained later to Sheryl). Sheryl then spoke with Andrew Bisits, who she knew as a colleague at the RHW. Andrew agreed to collaborate with her.

My pregnancy passed pretty quickly. Rowan was born at home on 8 July 2011 at 42 weeks. The birth was beautiful.

About six weeks later I went to Medicare with an invoice from Sheryl and received \$1120 of the total \$5000 back. I think in future Sheryl's clients will receive more. (Even though Sheryl began applying for her provider number in November 2010, she didn't receive it until May 2011, so I could only claim from then on.) At no time did anyone at Medicare ask to see any evidence of a collaborative arrangement.

From my perspective, my midwife's collaborative agreement allowed me to access Medicare, but really had no other impact on my care. I had no need to see a doctor during my pregnancy. My baby was a very active one and was breech one week, transverse the next then went back to breech before finally settling head down at around 37 or 38 weeks. In the back of my mind I was glad that Sheryl knew Andrew and had an agreement with him – if Rowan had been breech at full term then Andrew would hopefully have been able to turn Rowan or to help in a vaginal delivery. This was reassuring. I didn't ever feel that I needed care outside of the excellent care I was receiving from my midwives. I didn't mind that Sheryl was in an agreement with Andrew – he seems to be a lovely man with an excellent reputation for providing and supporting women-centered care. I had complete trust in my midwives so had they suggested at any point that I needed to see an obstetrician, I would have taken their advice. I also really respect Sheryl's philosophy as a midwife dedicated to serving women and if she was happy to collaborate with Andrew, then I felt secure in that arrangement.

Ultimately I feel I was very lucky. I realise that the collaboration arrangement

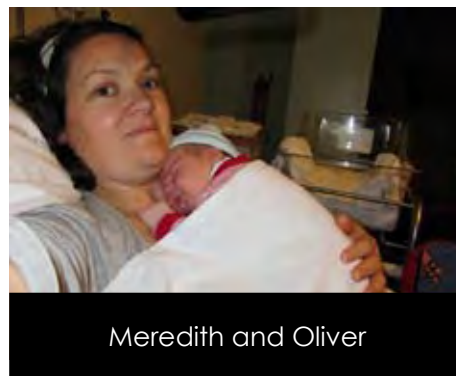
Sheryl has with Andrew is rare and most likely due in part to their established working relationship. I wish that more women were able to be cared for under agreements like this, not because I feel that midwives need to be overseen by obstetricians, but because it allows them to claim Medicare and therefore makes homebirth more accessible to those who could not otherwise afford it. I also feel that healthy collaboration can be important. If I had needed to see an obstetrician, for example if Rowan had been breech, then I would have been so much happier seeing one who my midwife knew and who hopefully respected my midwife's abilities.

I really hope that doctors and midwives reach a point where collaboration is easy, so women who do become high risk can receive continuity of care from their midwives with the input from doctors as needed.

In the summer edition of Birth Matters we'll look at collaborative arrangements from the perspective of privately practising midwives throughout Australia.

Collaboration through my eyes

By Meredith McLaren, Victoria



Meredith and Oliver

My first son was born via emergency Caesarean nearly three and a half years ago. I was well informed. I had a birth attendant. Things just went the way they did. I subsequently watched the health reform process with interest, submitted letters, and became saddened as my options for the birth I wished for diminished. I knew that if I became pregnant again I would employ an independent midwife, and I knew who it would be. When I did become pregnant I was lucky enough to be able to employ the midwife of my choice.

My midwife methodically explored my birth notes and I was finally able to put my first birth to rest. I knew that there was nothing else I could have done and that having the Caesarean was a good call. Over the next seven months a beautiful and respectful relationship formed between my midwife and family. We

planned for a hospital vaginal birth after Caesarean (VBAC). I attended obstetric appointments through the hospital. They told me they were happy with me having an independent midwife and wrote on my maternity record that I was seeing a midwife in private practice. We used this as 'collaboration' as we did not want to 'raise issues' by giving a formal letter. My midwife, at this point, had not had much success with collaboration.

I didn't receive much information about VBAC from the obstetric clinic. One particular obstetrician only provided the information I specifically asked for. When I went back at 41 weeks they informed me that they needed to book a Caesarean back up, and I felt under a lot of pressure. Against my wishes, the hospital booked a Caesarean for one day before my 42 weeks. My midwife gave me the courage to stand up and say what I wanted and to stick by it. She also provided me with all the relevant information about risks, etc. So I requested monitoring and a stretch and sweep and told the registrar on duty that I would not be having the booked Caesarean and would instead first like to try artificial rupturing of membranes.

I can't tell you the amount of negotiation that had to take place constantly over the next four days. Although most of my requests were respected (or at least adhered to), I felt as if I was being difficult. I laboured in the waiting room of the maternity ward, with people present, as there was no birthing suite available. I am a strong individual who knows how to say what I want, but I can see how easy it is just to do as you're told when you are in a hospital setting, in a vulnerable state. I hadn't intended to agree to a bung (intravenous access port), especially not in my hand, and I was going to negotiate continuous monitoring, but in the event I complied with both. This was much to the surprise of my midwife, who asked me why. I remember feeling that I didn't want to 'make waves'. One moment the hospital staff told me I *had* to have continuous monitoring, then, after I requested someone else to ask, I was told I could have 20 minutes off, and this was subsequently stretched to an hour. So which was right? It was simply a battle of wills. I was grateful to get an hour free from a machine that constantly had to be held onto me so that it would work properly; I can see that most women just don't get the choice. I could have pushed this issue further, but I feared how I would be treated.

In retrospect I wish I'd said that my midwife was my mum and saved us both from the tension we experienced with the hospital staff. They seemed to forget that she was not there to push for what

she wanted, but simply to remind me of our discussions and decisions over the past seven months. My midwife knew me, she knew my mental state and she knew my wishes. The staff members that were assigned to me that day/evening (and beyond) were strangers. They were put out from the start by the presence of my midwife and this manifested itself in the form of loud sighs, people leaving the room, answering curtly and showing blatant disrespect for her. The situation was uncomfortable, even to me in established (and very painful) labour. I was treated quite well for the most part, although I did feel I was shown an extreme lack of respect by staff who did not tell me they were doing a procedure during a vaginal examination or explain what was happening at each step.

After a long labour, there was not a lot more we could do. We won enough cooperation from the hospital to try things most VBAC mothers would not be allowed to try or might not even know were available. I am thankful for the knowledge and support of my most beautiful midwife. In the event my son was to be born by Caesarean. I continued with my negotiations in the operating theatre, and my decisions were all upheld. I'm sure those obstetricians were glad when I was out of their hands – troublesome woman!

There was an obvious lack of funding and resourcing of maternity services. Shiny new paint and a few extra beds is just a bandaid on a festering wound. I saw a clear need for education of staff regarding dealing with support people and about the ethics and respect involved in speaking about a patient in front of them. I was referred to as "the VBAC" on a few occasions. I was also sad to see that the midwives became subservient when the obstetrician entered the room. The way they spoke to me changed also.

I have many issues with my care, which I will address in a formal letter of complaint to the hospital. My complaints have nothing to do with having a Caesarean. I saw, heard and experienced things that would shock most people and I feel I need to raise these issues to minimise the likelihood that they will happen again.

Postscript: I wrote this story shortly after my son was born when the experience was still very raw. Reading it back stirs up mixed emotions – this was my son's birth, so it's a happy memory too. I don't want to make broad generalisations about hospitals as places to birth as I'm aware that many women do have beautiful births there. I think it very much depends on 'who you get' and your individual circumstances. I don't want my experience to make me bitter and in time I hope to be able to take something positive from it and do some good with what I've learned.

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Birth story: Would a known midwife have made a difference?



The writer of this story asked to remain anonymous. We thank her for this honest and intimate account of the birth of her second son in a busy rural hospital.

The lead up to the birth of our second son was a fairly intense period. At around 20 weeks my partner was sent interstate for three months. During this time our telephone contact was quite limited and although it was difficult, it did give me the opportunity to work through the experience of my previous birth. Our eldest son's birth had been long and hard and I continued to hold great fears about birthing another posterior baby.

At 27 weeks we receive notice that we will be transferred interstate in eight weeks time. I start to investigate my birth options for the new area. Without private health cover I have only one option – birthing in the local public hospital. Care will be provided via a midwife clinic where I will also see an obstetric consultant sporadically. There is no continuity and the midwives who work in the clinic don't work on the labour ward or provide care on the postnatal ward.

I begin searching for a private midwife servicing the region. There is nothing, absolutely nothing. So the weeks fly by. I look forward to the homecoming of my partner while also organising our move. When we arrive in our new area I'm 35 weeks and we begin the midwife search again and still we come up with nothing. The distance is too great for the one midwife remotely in the area to take us on.

At 38 weeks we have a tour of the hospital. I'm shocked by what I see and cry all the way home. We decide to labour at home for as long as we can, then transfer to hospital when I start feeling the urge to push. So, for the next few weeks, I try to feel comfortable with the idea of birthing in that vile place and also with the fact that because we are in

a new place with no family support and birthing in the hospital, our son will be cared for by a couple we have known for only five weeks. This has my partner and I both feeling quite anxious.

My 'due date' comes and goes. One week passes, then two. I'm approaching 43 weeks. I'm uncomfortable and desperate to meet my babe but am resisting the urge to be induced. Possibly the only benefit to having a baby in a rural area with a bed shortage is that there is no space for the women arriving in spontaneous labour, let alone those being induced. So there is no pressure on me whatsoever to have an induction.

At 42+6 we take our son to the local show. A pleasant evening and a big walk was exactly what I felt I needed. I remember feeling emotional about this being the last outing we would share with our son before he became a big brother.

At 9 pm we head for home. I complain to my partner that the doughnut I just ate has given me a stitch. We arrive home and get our son into bed when it occurs to me that I'm experiencing this stitch about every 10 minutes. I'm beaming as I tell my partner this is it. The physical distance we

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My legs are wrenched apart without my consent and the registrar forces his fist deep inside me. I'm offered no explanation and no sedation.

I'm gripped by fear. I'm screaming, crying for him to stop what he is doing and I vomit. My partner gets angry. "She told you to stop, what are you doing? She is telling you to stop." With his arm still inside me the registrar instructs a nurse to take our baby son from my partner and remove him from the room. The door is closed, my partner is not allowed back in and our baby is taken to another area. If my partner 'calms down' he can have the baby back. The registrar continues his search deep inside of me while the midwife continues ringing out my uterus. I lay there cold and naked. I stare at the ceiling and cry.

experienced over the last three months of my pregnancy still has us feeling a little uneasy in each other's space. He suggests a shower together. As he rubs my back I begin to feel closeness to him once again and I let him support me. After our shower we head to bed – my last labour lasted well over 36 hours so we know how important it is to not give this early stage any energy.

Asleep in my partner's arms I continue to feel tightening, eventually leading to me needing to be on all fours then upright holding the bed head. It is 1 am. We get up and I go to the lounge to use the fit ball. I want some time to myself, dark and silent. My partner calls our new friends to let them know he will drop our son over soon. I embrace my young son and shed a tear for this moment we will never again have. They leave and I get into my labour land. I nest, I cry, I breathe and I visualise. Each birth is different ... you know you can do this.

“

If we'd had a known midwife, a midwife who had seen our trauma occur, maybe my partner would have had someone to call when he was worried and lost. He probably would have called her when I was so obsessive about expressing at least 500 mls of breast milk a day that I would stay up all night. Our deep freezer was literally full with litres and litres of breast milk. It was crucial, you see, that I express that milk ... how else would my baby be sustained when I died?

I hear my partner return home and I'm relieved. I'm now moaning with each contraction, I want him near me. We continue our labour dance and shower again. In my bliss I feel that familiar out of control feeling. I vomit and know things are happening faster this time. My partner calls the hospital to tell them we are coming in. Driving in I quickly regret what seemed like such a good plan. The car is definitely NOT the place to be when you are in active labour. It is now 3 am.

At the hospital we make our way upstairs. We are told at the desk that it's one of their busiest nights ever – nine babies already today and the three birth suites are full – we will have to labour in a consult room. I'm sad as I look around the room. It is possibly the size of an ensuite and there is no room for me to move freely, no toilet, nothing. Eventually a midwife comes to see us. A birth suite is now available but she must “see where I'm at before she can give us the room.” I'm eight centimetres! “Good girl.” So off we go to our room. My partner settles the room by turning the lights off, he gets my music playing, I'm bouncing on the fit ball with my arms around his neck, he is kissing me and reminding me how close we are, he says I'm beautiful to watch, I am strong! My tightenings are so intense now that I'm receiving no break and my waters have not yet broken. Intuitively I know I'm fully dilated but I'm not yet feeling any urge to push so I continue labouring away, laughing with my partner, “This can't be it, it's been too easy.”

A midwife comes in and wants to see how we are going. I consent to another vaginal exam and find I am fully dilated

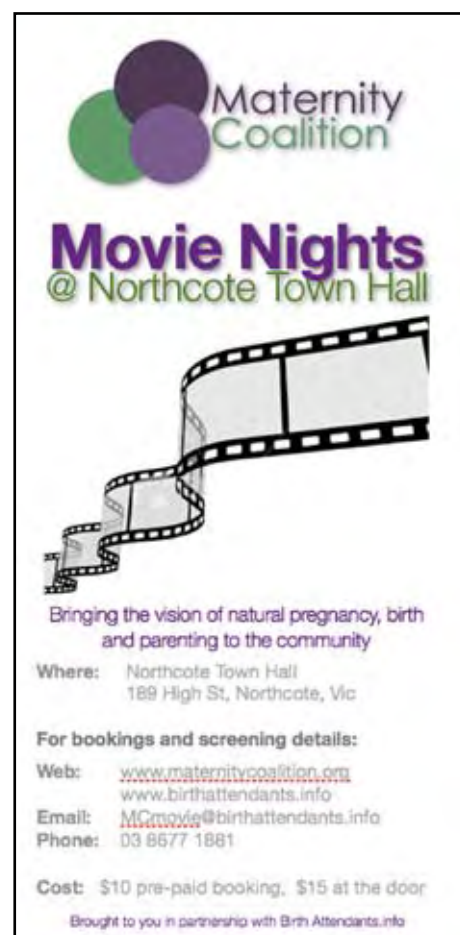
with bulging waters though the baby is still up very high. I tell her that for now we will continue as we are and reassess in an hour. An hour later I'm starting to lose my Mojo. I'm questioning my body and myself. The baby is still high and my membranes intact. The midwives are too busy attending to other things – they are not able to give us the support we need in order to get through this stage. I consent to having an artificial rupture of membranes. We are told we are going to have to move into the delivery room for this as the registrar “doesn't like amniotic fluid on his pants, like that last woman did to me” (the low bed in the birth suite meant he would have to kneel down). Stupidly, we assume I will have the artificial rupture of membranes and then return to the birth suite.

The registrar is rough. He says my membranes are thick. He gets angry that I won't stay still. Finally, gush, they are broken but still my baby is up very high. The staff are concerned as they say my last baby was big (9lb 1oz) – this one must be bigger, he seems stuck. I continue to bounce on the fit ball supported by my partner who asks them to give us some space. “The baby is fine,” he says. It is now 6 am. It dawns on me that as there are no toilets or showers in any of the birth suites or delivery room, I've not urinated since we left home.

Finally, supported by my partner, I feel my baby drop into my pelvis. The urge to push is overwhelming. I drop to my hands and knees – the top of my baby's head now visible – and reach down and touch the small slither of exposed scalp. The midwife is moaning behind me about her sore knees: “If you want me to catch this baby you better get on the bed!” I tell her I will stand, thank you very much. Here is the burning, burn, burn, burn, ROAR, ahhhhh ... eyes ... and now he's out to his chin. The midwife has her finger inside me freeing his chin. I tell her to move her hands away he is fine. I'm consumed by another urge to bear down and the midwife catches my babe. I turn around and take him from her. It is 6.51 am. I'm oblivious to the alarm which has been triggered, the people running into the room – the midwife's shouting, “Get on the bed, get on the bed!” I'm beaming. I glance at my partner, his face is white and he is asking me to get up on the bed. I look down and see blood covering the floor and my legs. I get on the bed, a midwife jabs my thigh with ergometrine, there's some pressure on my fundus, tugging on the cord and then, by putting his hand inside me and violently pulling it out, the registrar has manually removed my placenta. I am distressed, I don't even know who this man is and no one has

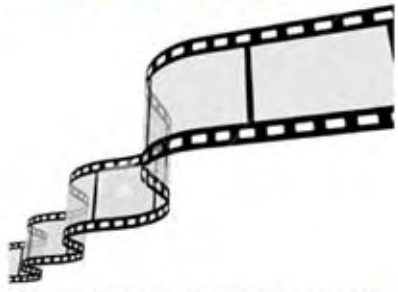
explained why he put his hand inside me. I am panicked and continue to gush blood. The registrar instructs one of the midwives to perform an exercise on my uterus. My husband is holding our baby now. The exercise is similar to the way you would wring out a wet towel – over and over she wrings out my uterus, the pain is excruciating and she is plunging her hands so deep into my belly I feel like she is grabbing my spine. Another midwife catheterises me and is shocked by the amount of urine she collects. My legs are wrenched apart without my consent and the registrar forces his fist deep inside me. I'm offered no explanation and no sedation. I'm gripped by fear. I'm screaming, crying for him to stop what he is doing and I vomit. My partner gets angry. “She told you to stop, what are you doing? She is telling you to stop.” With his arm still inside me the registrar instructs a nurse to take our baby son from my partner and remove him from the room. The door is closed, my partner is not allowed back in and our baby is taken to another area. If my partner ‘calms down’ he can have the baby back. The registrar continues his search deep inside of me while the midwife continues ringing out my uterus. I lay there cold and naked. I stare at the ceiling and cry.

What feels like an eternity passes and the door bursts open – it is another midwife followed by my partner. “What the hell is going on in here?” she bellows. “Get



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your hands off her stomach... why in the world would you be doing that?" Then she turns on the registrar, still with his arm inside of me. "Have you even inspected the placenta before carrying this out?" The registrar claims he doesn't know where the placenta has been taken. "It's in the bowl next you!" the midwife says as she storms out. I looked at the stainless steel bowl sitting by his side, containing my full and completely intact placenta.

I think I passed out around then, as my recollection is quite limited. I remember waking to my partner, being back in the delivery room, my partner placing blankets on my naked bloody body. He is crying telling me they told him I almost died, I'd lost 2000 mls of blood and would need a blood transfusion. I remember a nurse instructing him that he had to leave, it would be best if he went and picked up our older son.

I remember lying still in that delivery room, crying for my baby and listening as he was being held by staff in another room. I passed out again.

The midwife who earlier bellowed at the registrar wakes me. She tells me she is taking me up to the ward. In her arms is my baby, bathed and clothed. She apologises. I'll never get those precious moments cuddling my naked dirty baby back. She settles me in on the ward as my partner arrives with our older son. I breastfeed my boy for the first time. He is 9lb 11.5oz. It is 1 pm. I remove his clothes and tuck him in bed with me. I am desperate to bond with my son but my body is numb. All I can think about is what that man did to me.

Our older son is fussing – a hospital is not at all appropriate for a two year old. I tell my partner he should take him home. I'm tired anyway. A midwife enters and informs me that "babies are not allowed to co-sleep here." I tell her I don't care what the hospital has to say. She returns with a contract I must sign acknowledging that I am aware I have a high chance of smothering my baby.

That night my partner returns to see me. Still I am numb and can't stop thinking about what happened. I want to go home – I'm scared I am going to see the registrar on the ward or, worse, during morning rounds, but I can't leave as I am still being told I need a blood transfusion, which I continue to decline. The next morning we sign me out because I just can't be in that place any longer. I receive absolutely no postnatal care. Thinking about the experience even now makes me vomit.

And so, that's it. That was the experience that changed my entire life. I've never been the same since. Not a day goes by that I don't think about the experience, nor does a day pass that I don't see that

registrar's face. The experience almost ended my relationship – it certainly killed some aspects of it at any rate – and I worry about the impact it has had on my mothering ability. All my boys know is this obsessively clean, control freak who shies away from her partner's touch.

What if I had had a known midwife by my side? Chances are the haemorrhage would still have occurred, however the management of the haemorrhage may have been different. Maybe my known midwife would have tried other treatments in order to stop or slow my bleeding. Maybe the registrar would still have been called, but perhaps I'd have been less petrified of the procedure if my midwife had been by my side, holding my hand and telling me what was happening. Maybe my partner would have had an opportunity to have some understanding. There is a chance that events would have taken the same course and the procedure would have been no less terrifying than it actually was. However, had I had a known midwife, I would have received postnatal care. The midwife would have come to my home after my son's birth and, based on the relationship we had built in the antenatal period, would have been able to see instantly that things were not right.

Perhaps she'd have noticed my self-imposed exile to my bedroom. Perhaps she'd have sensed that actually my absolute vigilance with regard to my baby was not impossibly dedicated mothering but, rather, I was in a heightened state of alert. Maybe she would have known that my lack of sleep was not because my baby had me up all night but because I

couldn't sleep. Ever. She'd have returned to our home at six weeks post partum and maybe she'd have walked in on me having a panic attack in the kitchen or perhaps she'd go to the kitchen to make a coffee and she would see there was no milk. Maybe she'd ask why there was no milk and then I would be able to tell someone that there is no milk in my fridge or food in my pantry because at the end of a big grocery shop this morning a smell in Coles took me back to that moment of powerlessness, vomit rose in my throat, I had to abandon my full trolley and dash with my two young sons back to my car where I could have a panic attack privately.

If we'd had a known midwife, a midwife who had seen our trauma occur, maybe my partner would have had someone to call when he was worried and lost. He probably would have called her when I was so obsessive about expressing at least 500 mls of breast milk a day that I would stay up all night. Our deep freezer was literally full with litres and litres of breast milk. It was crucial, you see, that I express that milk ... how else would my baby be sustained when I died?

If we'd had a known midwife I would probably have called her when, at seven months post partum, I was pregnant with my third baby – a baby intentionally conceived in a desperate effort to find some sort of healing.

But we didn't have a known midwife. So all of the above (and more) occurred without anyone noticing and without anyone able to help me.

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Birth for the women of Bourke

By Mary-Kate Ferguson



Supporters of Bourke Birthing Action Group rallied out the front of Bourke Hospital before a recent meeting with representatives from Western NSW Local Health District, including Acting CEO Lyn Weir

Birthing services in Bourke were 'temporarily' suspended more than two years ago and have never recommenced. In this update Mary-Kate Ferguson explains what the lack of local birthing options really means for the families of Bourke and its surrounding areas, and reminds us that, despite the ongoing reform process, nothing much has changed for women in the bush.

We would all like to think that, as Australians, we have access to vital government services like healthcare and education. What about the way in which a woman gives birth? Do you take for granted that your wife, sister, mother or daughter will have access to local care and the support of her medical practitioner, family and friends? The residents of Bourke don't. It has been over two years since the birthing unit at Bourke hospital was temporarily suspended due to staff shortages and, since then, expectant mothers have been forced to travel almost four hours to Dubbo, or even further to other regional centres, to give birth.

The problems that this birthing exodus creates are wide ranging. For most residents it is a logistical nightmare to be uprooted (generally two weeks before the birth); find and pay for accommodation; give birth away from one's support network; and then travel back to Bourke – often alone – with a tiny newborn as a travelling companion. What is a family to do with existing children? Who takes care of them? Who goes to work? Somebody has to work, as the cost of all this is

prohibitive. It's also emotionally exhausting.

The stories from women about their experiences are extremely distressing. One woman (who went into early labour three times) was flown out to Dubbo, on to Newcastle and then back to Dubbo. By then her labour had stopped, so the hospital staff discharged her at 3 am with the expectation that she would make her

own way back to Bourke, heavily pregnant and due to give birth at any time. This is just one of many similar examples.

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To a town like Bourke, a birthing unit could mean many things – employment, security, increased health and safety for women and children, business opportunities – and offer support to surrounding communities... It could mean feeling a little less isolated, a little more connected with the services so many Australians take for granted, and it could make birth a community experience.

There are those who just can't afford the expense. Women have refused to leave Bourke and laboured and birthed at the Bourke Hospital under emergency circumstances. These women are then required to go, with their newborn, to Dubbo for further medical care and assessment. One particular woman refused to leave (knowing she did not have the means to travel back to Bourke) and was threatened with being reported to the Department of Community Services.

Dubbo hospital is overworked and understaffed – it is just too much to expect one regional hospital to cater for the entire western region. It is essential not only for the women in Bourke, but for the women in Dubbo and all the nearby regions, that the birthing unit in Bourke is reopened to serve the women of this community and our surrounding towns.

The new maternity service is currently awaiting the go-ahead. Two new midwives have moved to Bourke especially to support this service. They will work alongside another long-time Bourke midwife and the local GPs. The midwives are currently providing antenatal and postnatal care and, once the unit is reopened, they will provide continuity of antenatal care (including antenatal classes), a known midwife on call for all births and postnatal care for up to eight weeks after birth.

Western NSW Local Health District Acting CEO Lyn Weir has assured members of the community and the Bourke Birthing Action Group (a group of local mothers and community members who have been lobbying for the reopening of the birthing unit) that the unit may reopen in November this year. The residents are hopeful and, understandably, a little sceptical. The town needs the support of the Government, the media and concerned members of the greater community to ensure that the birthing experience for the women of Bourke is one that is provided locally, without the stresses of travel, money and isolation from family and support.

To a town like Bourke, a birthing unit could mean many things – employment, security, increased health and safety for women and children, business opportunities – and offer support to surrounding communities like Cobar, Brewarrina, Enngonia and Louth. It could mean feeling a little less isolated, a little more connected with the services so many Australians take for granted, and it could make birth a community experience – an experience that brings back to Bourke the one thing that has been linked to birth since the dawn of time. It could bring back hope.

Birth experiences of the women of Bourke

Belinda

I had both of my babies here in Bourke, at the old hospital. My daughter's birth

was not easy. I was induced and laboured well, but her arrival into the world was via forceps. There were a few issues after her birth as well. I owe so much to the staff of the hospital and to my local doctor for handling things so beautifully, but what made it even more amazing was the personal nature of the event. My midwife was a previous client [of mine] who, even after her shift was finished, very late at night, refused to leave – she wanted to see our baby born.

And that's the absolute crux of this issue – women feeling comfortable, safe and familiar as they go through the journey of birthing their baby. It is also so important for family members to feel secure and connected in this situation. If by chance the birth is not going well, they have those local faces to look to.

My son's birth was a Caesarean, here in Bourke, also in the old hospital theatre. It was a really special time. In a room full of theatre staff I knew the faces behind all of those surgical masks. There were tears from a lot of them too when he arrived, because they were able to share in the joy personally. I had big, beautiful babies born at Bourke – the best place in the world.

Anonymous

September 2009 – When I was due to give birth there were no maternity ward services in Bourke. I had been assured by the hospital that it would “be open for sure by September!”

Due to complications in my first birth, my doctor and I agreed that an elective Caesarean was necessary, so I made an appointment to see an obstetrician in Dubbo. After several visits I was booked into Dubbo Base Hospital for an elective Caesarean on the 28 September 2009. At 39 weeks I packed everything I thought I may need into a suitcase and, with my husband and three-year-old son, drove 365km to Dubbo. We checked into a motel, which was our home for the next five days.

Our beautiful second son was born on Monday the 28th and all was well until the three-day blues crept in. In hospital I missed my first son and husband terribly and longed to be home. The hospital was understaffed and overworked. The care I received from the midwives was barely satisfactory (due to their work loads) and nothing like the personalised care I had received at Bourke.

At 5 pm on the Thursday after giving birth, I was discharged with no motel to go to as it was school holidays and all of Dubbo was booked out, so it was back to Bourke. We left Dubbo with a three year old and our newborn and arrived home at 10.30 pm after a horrible trip in the dark.

Once home, my husband had no choice but to go back to work (out of town).

But our family support network was available so everything was fine. When I began to feel unwell I thought I had been over doing it. I had a community-based midwife doing regular home visits for me as things just were not right and my wound was inflamed. It wasn't until a Friday afternoon about two weeks after the delivery that I was home alone with my newborn and realised I needed urgent medical help. My Caesar wound was bleeding and I was in excruciating pain. The midwife had given me her mobile

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number in case I had needed her over the weekend. I put my baby in his cot, grabbed a clean towel for the wound, unlocked the front door, got my phone and laid on my bed with pressure on the wound, then rang the midwife and my husband. The midwife was there within minutes – she assessed my situation and made arrangements to transport me to hospital.

A doctor was called in and diagnosed me with a hospital-grade Methicillin-resistant *Staphylococcus aureus* (Staph) infection in my wound and the capsule holding it had burst, causing the wound to slightly reopen because of the severe infection.

Our next problem was no anaesthetist in town. So, under a local anaesthetic (otherwise I would need to be airlifted back to Dubbo Base, where the problem had originated), I had the wound cleaned and a drain sewed into place for the next four days. Before I was taken into theatre I was advised that it would be best to give my newborn son a breastfeed because once I came out I would be on strong IV antibiotics and therefore unable to breastfeed him.

With the help of my midwife, I expressed four hourly for the next week to keep my supply up, in the hope that I would still be able to feed my little man. When I was finally allowed to recommence feeding

him I was devastated to find that he wouldn't feed.

I persevered and tried so hard, but in the end I had to admit defeat as he was just not interested. During my stay in hospital I was expressing and producing milk and my son wouldn't settle – I believe he could smell the milk but was unable to have it. I felt I had no choice but to send him home to be cared for by his dad until I was well enough to come home again. So my husband was off work, at home, caring for a three year old and a newborn. What a great job he did! Eventually I was well enough to go home too.

September 2010 – This time I made the decision straight away to be a private patient, based on my previous negative experience with the public system. I knew that I would have to travel to give birth as it was my third Caesarean (and my second was less than two months prior).

At 39 weeks, once again, my husband and both our sons drove with me to Dubbo and spent five days in a motel. Our daughter was born at the Dubbo Private hospital via Caesarean-section on 23 September. The care we received was fantastic. I had anything up to three midwives at a time, which made the whole experience much more relaxed, and I was able to get the rest I needed this time, before travelling back home. I was released at 10 am instead of 5 pm and had a safe, relaxed trip back to Bourke in daylight hours.

Our daughter was diagnosed with clicky hips at birth (breech in utero) and therefore was placed in a pelvic harness for eight weeks from the age of six weeks, but responded to treatment well and is fine.

We were lucky that a Bourke doctor is qualified to do harness adjustments so we only had to travel to Dubbo a few times during this treatment.

After the incident with my second son I actually wrote an email to our local MP – to this day I have had no reply. (My son is 2 in Sept.) I know they received the email because I regularly get their newsletter, which I have now re directed to my junk mail box!

I knew that I would most likely have to travel for my second son's birth due to the risk factor, but even if I could have been transferred back to Bourke to recover, I would have felt a lot better. This type of arrangement [for postnatal care] would take a lot of pressure off Dubbo hospital and also off families when they can be near their support networks.

For more information about the current situation in Bourke contact Korina Ivatt on 0431 534 813 or email korinaivatt@bigpond.com.

Birth in water: supporting women with midwifery knowledge and skill

By Roz Donnellan-Fernandez



Megan Boswell born through water into the waiting arms of mum Carla Lewenhoff

The following article is based on an education workshop for midwives presented at the Australian College of Midwives South Australian Branch Twilight Seminar held at Flinders Medical Centre in 2010.

Optimising physiologic childbirth and the humanisation of birth

Birth in water is sometimes portrayed as a new-age hippy fad promoted by modern childbirth fundamentalists to push the boundaries of normal birth, but I see it as a small part of a much bigger and more sophisticated idea. Birth in water is connected to the movement to humanise birth, a movement with the potential to profoundly affect the evolution of a more conscious human culture, encompassing supportive human relationships based on respect, compassion, care, trust and self-determination (Beech, 1996; Balaskas & Gordon, 1990; Garland, 2000; Odent, 1990).

This is a powerful idea and more expansive than birth in water for its own sake. Physiologic childbirth enhances many aspects of the woman's and newborn's physiology: the primal adaptive system, early neural pathways and hormonal and immunologic patterns are established and influenced for life at the time of birth, in accordance with nature's blueprint and design (Buckley, 2006; Odent, 2002). This is significant for both current and future health.

Why water?

Modern Western culture is currently experiencing unprecedented levels of fear of vaginal childbirth, as evidenced by the epidural epidemic prevalent amongst first-time mothers (upward of 70% in many large public maternity hospitals in Australia, and even higher in the private sector). Additionally, according to Australian Bureau of Statistics data, the rate of Caesarean sections is now upwards

of 30% in most Australian states. This surgical operation has consequent short- and long-term life course morbidities for women and babies that are both physical and mental (Odent, 2004).

While pregnancy and birth are physiologic, emotional, psychological, cultural, spiritual, social and sexual experiences, predominant Western practice is to locate birth within an obstetric, specialised medical context. The privileged application of science and medicine within high-technology, centralised hospital environments (often based more on dominant ideology than sound evidence) constrains the opportunities for physiologic childbirth. This compromises the level of support, culture and services that optimise physiological childbirth, which in turn significantly influences cultural perceptions, beliefs, expectations, service choices and outcomes. The end results are high levels of indiscriminate intervention in normal birth, compromised rates of vaginal birth and subsequent consequences for the health of mothers, babies, families and Australian society as a whole (Donnellan-Fernandez et al., 2008). Additionally, conflict or stress between the 'primitive brain' and the 'rational brain' during labour can impede the hormones and processes that facilitate physiologic childbirth (Buckley, 2006).

Water, a feminine symbol and an environmental resource, is a medium that holds the potential for effective intervention. It can help women to rediscover the instinctual embodied knowledge that optimises and supports physiologic, vaginal childbirth (Odent, 1990). The use of water enables many women to cope better with the strong sensations of childbirth. Warm water immersion is associated with increased mobility, control, comfort, maternal satisfaction, the optimisation of instinctual behaviour and the progress of vaginal birth (Burns & Kitzinger, 2001; Balaskas & Gordon, 1990; Garland, 2000; Maude & Caplice, 2010). Importantly, it is also associated with a reduction in the use of pharmacologic pain relief and a minimisation of medical interventions. This benefits mothers and babies, who are more alert, responsive and satisfied (Enkin et al., 2000; Green, Coupland & Kitzinger, 1990). A prospective observational study undertaken in Switzerland found that babies born in water had the lowest rate of neonatal infection and a higher average Apgar score at five minutes. Women birthing in water had the most satisfying birth experiences, in addition to the lowest

rate of analgesic use, lowest episiotomy rate, lowest incidence of third- and fourth-degree tears and lowest maternal blood loss (Eberhard & Geissbuchler, 1999). Other surveillance studies and scientific reviews have also supported the safety of birth in water for healthy pregnant women and their babies at term (Gilbert & Tookey, 1999; Nikodem, 2001).

In 2010 women in Australia birthed approximately 300 000 babies. The mantra of Maternity Coalition is: *Every woman, every choice*. In the 21st century it is important that midwifery knowledge and skills are able to meet the expectations of childbearing women and their families. This increasingly includes the use of water for labour and birth.

A brief history of water birth

Birth in water, which has ancient origins, has attracted diverse interest over the past half century. Russian swimming instructor Igor Tcharkovsky investigated the capacities of human babies in water and the relationship between humans and dolphins, pregnant women and babies in the 1960s. Frederick Leboyer, a French obstetrician, practised immersing newborns in warm water throughout the 1960s, with the aim of easing the transition from the womb to the outside world post birth. Michel Odent, initially a surgeon, began using a warm water pool for pain relief for labouring women at a birth centre in Pithiviers, France throughout the 1970s and 1980s. Many women progressed to giving birth in the pool. By the 1990s thousands of women had given birth in water and the idea had spread to many Western countries as part of a movement to reclaim normal birth by using natural resources to support women's inherent physiology (www.bellybelly.com.au/articles/birth/waterbirth-birth-in-water). Many childbirth activists and educators (e.g. Janet Balaskas, Sheila Kitzinger and Beverly Beech), supportive medicos (e.g. Yehudi Gordon and Michel Odent) and midwives (e.g. Diane Garland, Ethel Burns, Robin Maude and Shea Caplice) have sought to advance the uptake of water immersion and birth in institutionalised birth settings. By the mid 1990s the first international waterbirth conference had taken place in the United Kingdom: *Water Birth Unplugged* (Beech, 1996). By 2010 three quarters of UK hospitals provided this option for birthing women. Multi-media dissemination of knowledge has been enabled by the worldwide web and social networking. There is a correlation between the number of women who access information about



Midwife Marg Phelan frees the cord as baby Saffy surfaces to meet mum Kylie

childbirth via these sources and an increase in vaginal birth rates, suggesting that the democratisation of information may counter/offset some of the cultural and health system influences that currently impede physiologic childbirth.

Guidelines for labour and birth in water

Whilst the application of heated towels and the use of warm showers are common practices in many environments, immersion and birth in water still present a challenge and a practice prejudice for some caregivers in some settings (Wattis, 2010). There is no simple formula for the use of water during labour and birth and it is not a method that can be evaluated by double-blind studies or randomised controlled trials (although, unbelievably, some have tried — see *Challenging Water Birth – How Wet Can it Get?* (Keirse, 2005)). Attraction to water varies considerably from one individual to another and it is not a panacea for all. While it can assist some labouring women to liberate their instincts, like any intervention, it can also complicate birth if it is used unwisely (Odent, 1998).

Physical and emotional benefits

Warm water immersion:

- facilitates mobility and control; the woman herself can assume any comfortable position for birth
- reduces abdominal pressure
- conserves energy
- may speed up labour
- may reduce blood pressure
- promotes relaxation and relief of sensations (private, protected space, weightlessness, warmth, can enhance hormone secretion)
- reduces the need for drugs and interventions
- changes consciousness, reduces inhibition
- reduces perineal trauma
- may facilitate the second stage and provide an easier birth for mother and baby
- is highly rated by women

Considerations for the woman

As a birthing woman you should:

- prepare your mind; be flexible with

expectations; ensure you have a skilled attendant (midwife)

- ensure the pool or bath is comfortable: deep enough; hard or soft sides; length of time to fill
- ensure the water is clean and at a temperature of 35–38°C
- choose a suitable room with a sound floor to hold the weight of the water-filled tub, adequate access for the birth attendant and a heat source; prepare clean towels and wraps for the baby
- eat and drink for energy: avoid dehydration – drink a minimum of 300 ml every few hours
- enter the pool in established labour/strong contractions (5 cm cervical dilation); get out if progress slows
- be prepared to deal with debris: use a sieve for clots, mucus, vomit, faeces
- adopt any position that works for you – kneeling, sitting, squatting, leaning, floating
- bring the baby to the surface when born; he or she will breathe when stimulated by air; blow on the baby's face if they are relaxed; assess the cord for heart rate
- be aware it is best to deliver the placenta out of water — there is a theoretical risk of water embolism
- be reassured that there is no evidence of increased infection risk for mothers or babies from water; there is also no increased risk of infection for the midwife (Hepatitis A,B , C or HIV) due to virus dilution in water, although open abrasions should be covered (long latex vet gloves should be available for added protection) (www.bellybelly.com.au/articles/birth/preparing-for-a-waterbirth).

Midwife responsibilities

The midwife should:

- facilitate normal birth physiology for mother and baby: simple!
- maintain a private, low-stimuli environment to minimise stress hormones (noradrenaline and catecholamines) and maximise oxytocin and endorphin release
- carry out routine midwifery observations as with land birth, as per ACM National Midwifery Guidelines for Consultation and Referral (2008); use waterproof doppler to auscultate foetal heart rate
- remain vigilant and alert for complications as with any birth
- monitor water temperature (35–38°C) to avoid haemodynamic compromise of mother and baby; i.e. overheating, dehydration, blood pressure fluctuations and postpartum haemorrhage

- ensure adequate depth, coverage and cleanliness of water
- be discriminating about the use and timing of warm water immersion relating to progress of labour: i.e. in established labour (5 cm cervical dilation or greater) it can facilitate progress; less than 5 cm can inhibit oxytocin and stall/prolong labour, leading to possible dehydration and exhaustion); there's a need to assess wisely
- maintain the woman's hydration: water intake; cool cloth for face; spray mist bottle
- perform vaginal examinations (if necessary) in the water or ask the woman herself
- encourage the woman to follow her body's natural urges to push/breathe her baby out; hands-off birth is fine as water supports crowning and perineum, although many women instinctively support their own perineum
- bring the baby to the surface within the first few moments of birth to initiate respiration in air and await cessation of cord pulsation; water babies are often very relaxed and appear asleep when brought to the surface; the mother can be encouraged to blow on the baby's face and provide tactile stimulation if required; have resuscitation equipment prepared and ready as for standard midwifery practice ¹
- keep the mother and baby warm; ensure accurate estimation of blood loss (often there is none apparent) — note the colour of water: 'Rose is OK; Claret is NOT' (although assessing the status and condition of the woman's response is the best guide); some institutions such as Women's & Children's Hospital in Adelaide have developed visual charts to guide estimation of blood loss
- observe closely for signs of placental separation (i.e. lengthening cord; gush of blood; contracted fundus) and exit the pool for warm wraps and birth of placenta/third stage management: there is a theoretical risk of water embolism in water, although the placenta is sometimes birthed quickly prior to the woman exiting the bath
- initiate early breastfeeding and routine care and post-birth observations, including support of the family
- be aware of Occupation Health & Safety Considerations: consider back care when attending a woman in a pool; minimise infection risk for self and other users of the facility by ensuring appropriate care and cleansing of equipment (Maude & Caplice, 2010)



Liza, David and daughter Radhiocea Kennedy welcome baby Tokoda, born through water

Managing complexities and challenges

As with any birth, unexpected midwifery challenges may arise in relation to water immersion and birth in water. These range from the mildly challenging (e.g. nuchal cord at birth, or continuous monitoring for a woman who has experienced a previous Caesarean section), through the moderately confronting (e.g. undiagnosed vaginal breech, or immersion exclusion criteria for women who are of large body mass index or pregnant with twins,) to far more serious complexities, such as the need to evacuate a woman from a pool to manage an obstetric emergency (e.g. a shoulder dystocia or postpartum haemorrhage). Whilst complication rates for healthy mothers and babies undertaking birth in water remain low, vigilance and preparedness to manage unexpected situations remains the professional responsibility of the midwife attending.

1. Inhibitory factors prevent the baby from inhaling water. 24–48 hours prior to the spontaneous onset of labour, increased levels of PG E2 levels are produced by the placenta to slow foetal breathing movements. Normal birth causes apnea and swallowing, not breathing and gasping (provided no hypoxic compromise or insult). Water is a hypotonic solution and lung fluid in fetus is hypertonic (dense). The dive reflex is an autonomic newborn reflex for glottis closure and swallowing, not inhaling – this reflex is present until 6–8 months of age. (www.bellybelly.com.au/articles/birth/waterbirth-birth-in-water)

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Roz Donnellan-Fernandez

Author Bio

Roz has been practising midwifery publicly and privately in hospitals, birth centres and community settings since 1994, facilitating homebirths and water births. She was Joint Unit Head of the Midwifery Group Practice at the Women's & Children's Hospital, Adelaide 2003–2008 and has participated in SA Department of Health Committees to develop statewide guidelines for planned birth at home and policies for the safe use of water immersion during labour and birth (<http://www.health.sa.gov.au/PPG/Default.aspx?tabid=189>). Roz aims to help other midwives to develop the skills, confidence and formal accreditation required when attending labour and birth in water.

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*a non-refundable \$20 deposit is payable upon booking.

'Working' for MC – worthwhile, flexible and fun

By Bec Telfer



August 2011 Birth Matters mail out – Bec (centre) is helped out by her sister Jenni and her mother Wendy while they were visiting

Membership Secretary and Birth Matters distributor Bec Telfer explains what drew her to Maternity Coalition and why she keeps "plodding along in the background."

I first joined Maternity Coalition in 2006 when I was studying midwifery. I had a seven-month-old baby who had been born in the Mackay Birth Centre, but we had moved to Toowoomba for my husband's career and for me to do my student year at Toowoomba Base Hospital. I was horrified to find out that every hospital didn't come with a birth centre, as it seemed logical to be able to choose to birth there or the hospital. I had two inspirational lecturers that year, who introduced me to MC and instilled in me the Margaret Mead quote to "never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that

ever has." I believe MC members are some of these committed citizens.

We moved to Stanthorpe in 2007, and I fortuitously met Alison Gaffney at a mother's group held in a Nursing Home. We were kindred spirits in our desire to see all women have access to a known midwife during their pregnancy, birth and postnatal period, and together we started the Stanthorpe BaBs group in September 2007 – this year we celebrated our fourth birthday.

The following year Alison heard that MC needed someone to take over the role of distributing Birth Matters Journal, and so we both put our names down. Every three months we would invite our friends (and their kids!) over to help address and stuff envelopes with magazines. It would take us a long time, but it was fun. Since then I have managed to streamline the process, and now do it myself over a couple of evenings.

The Membership Secretary position became vacant when my third child was two months old. The magazine distribution role is intrinsically linked to the Membership Secretary role, so it seemed natural to put my hand up. It is a position I have enjoyed, as I feel like I am providing a crucial service within MC, without feeling like I have to be politically savvy. I struggle to keep on top of everything that is going on politically in maternity care in Australia, but I am quite

happy plodding along in the background, trying to keep the database of addresses and memberships up to date.

I have been in some form of paid employment since I was 15 years old, and then I had children. MC has provided a 'work' outlet for me, albeit an unpaid one, as everyone who works for MC is a volunteer. It has flexible hours, is breastfeeding friendly and I've met interesting people all over Australia (via email and Skype). It has also allowed me to develop skills I otherwise probably never would have, as I am much more computer literate than I was a few years ago. I recently applied for a part-time job and was amazed at my new CV. The gaping hole I was expecting to see while I had three children had been filled by my work with MC. The beauty of working with MC is its flexibility. When things are running smoothly at home I manage to keep the database up to date and get membership letters out in a timely fashion. When things are going a little pear shaped I might not do any MC work for a fortnight (or more), so I apologise to all of you who have wondered where your receipts are! Working for MC has enabled me to contribute to something I feel really passionate about while I parent young children. There are many other 'little' jobs within MC, such as working with the Birth Matters team as a writer, proof reader, sub-editor or advertising coordinator; assisting the Treasurer or one of the other office bearers; or being a regional contact person. Who knows where any of those positions might take you!

CAN YOU REACH OUT TO AN AUDIENCE?

VOLUNTEER POSITION VACANT

Passionate about choice for women in childbirth, and want to help out?

MC needs to grow so that we can spread the message further. We need to do more work behind the scenes to strengthen our organisation and achieve more of our goals sooner!

Birth Matters is looking for an
ADVERTISING COORDINATOR.

For a complete job description please email:
birthmatters@maternitycoalition.org.au

**ADVERTISING
COORDINATOR
WANTED**

Maternity Coalition News

Northern Rivers Branch

By Sally Cusack

Pregnancy, Birth and Beyond Radio Show

Our radio show on local community radio BayFM is continuing to develop and we have been on air for 11 months now. It all began when we presented a screening of Rani O'Keeffe's film *Throwing out the Lies with the Birth Water*. We were very inspired to see the presenters of Birth Hour on Blue Mountains community radio share information about natural birth.

With very little time to spare, Nicole Foder and Anna Aranci stepped into the role of co-presenters, something that was very new to both of them. They both had a wonderful experience learning new skills together and interviewing people from all over our region. Nicole and Anna have had to step aside for now but we were very fortunate to have Taneal Blake step in to replace them. Taneal has shared her experience as a mother, doula and midwife in training on the show and has now taken a break to prepare for the birth of her fifth baby. Stepping into the role are Lara and Hunna – both mothers of young children with a lot of enthusiasm and experience to share with our community. We are so thankful for all the women who have participated in our show. They all work so hard on learning radio presentation skills so quickly and putting together the show each week. Without them, all these amazing stories we have heard would not have reached the wider community.

Our basic format is a one-hour show with interviews with music. The interviews are with parents sharing their experiences and professionals who have specialist information to share. A few weeks ago we had a local mother come in to share her story about the homebirth of her twin boys. Another couple have spoken about their nappy-free experiences with their children. A couple of months ago we heard Nicole Foder's interview with Dr Michel Odent, a fantastic opportunity for all of us. So many people have been interviewed on our show this past year, we all benefit from making these connections throughout our community.

Feedback on ACM Interim Position Statement and Guidelines

Our branch made a submission to the ACM on their recently release interim documents and we have started a campaign encouraging our local supporters to make their own submissions. A link to our submission is on our facebook page: www.facebook.com/MaternityCoalitionNorthernRivers.

Red Tent Festival

We have started planning another Red Tent Festival – A Celebration of Women and Birth early in 2012. Our first festival was held in November 2009. The festival will follow the same formula of films, workshops, talks, birth stories and performances over one day and into the evening. Our festival project team has been formed and planning is well underway.

Southern Cross University Review of Bachelor of Midwifery Degree

In August Professor Kathleen Fahy from Southern Cross University launched a review of their Bachelor of Midwifery degree. As part of the review process, Professor Fahy has invited a broad range of stakeholders to participate in the review, including our branch. We welcome the opportunity to provide our feedback on the training given to midwives.

To contact The Northern Rivers Branch, email maternitycoalitionnr@gmail.com.

MC Tasmania

By Georgia Hodges

Key happenings for MC Tasmania since July are listed below.

- Community Consultation for Midwifery Group Practice to be set up at the Royal Hobart Hospital. MC members have been attending these meetings. There have been two so far.
- Kelly Madden and Liz Enkins have met with the Acting Director for Women and Children at Royal Hobart Hospital regarding the development of the Women and Children's precinct. Federal Independent Andrew Wilkie managed to get federal money to contribute to the building of the Women's and Children's Precinct.
- MC Tas was invited to attend the Privately Practising Midwives credentialing workshop (hospital visiting rights). We were unable to attend because of the location (it



WANTED!

Honest and constructive feedback

If you would like to comment on the content of Birth Matters or share your ideas about anything

birth related, please email [birthmatters@](mailto:birthmatters@maternitycoalition.org.au)

[maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au).

was not in Hobart). However the Department of Health and Human Services is keeping us in the loop and sent the minutes of the meeting and a request for MC's comment.

- Kelly Madden and Georgia Hodges (with babe in arms) met with Andrew Wilkie Federal Independent for Denison to congratulate him on getting the money for the development of the Women's and Children's Precinct and to inform him about collaborative arrangements vetoing women's access to the Medicare rebate in Tasmania. Andrew Wilkie agreed to meet Hon Nicola Roxon in November this year (as it will be 12 months since Eligibility and Medicare for PPMs) and ask her how many women have claimed the Medicare rebate for Maternity Care.
- Genevieve has been busily meeting with politicians and informing them about MC.
- Georgia Hodges met with Tasmania Breastfeeding Coalition to inform them about MC and discuss working together to improve maternity care for women in Tasmania.
- Kelly Madden will be attending the discussion about antenatal handheld record on 30 August 2011.
- Genevieve has applied to the Tasmania Clinical Networks to be a consumer representative. This will be very beneficial to MC in Tasmania.

If anyone would like to attend a monthly MC meeting in Southern Tasmania please contact Georgia Hodges on info@maternitycoalition.org.au.

MC Victoria

By Ann Catchlove

Maternity Coalition Victoria is hosting the Australian premiere of the *More Business of Being Born - Down on the Farm: Conversations with legendary midwife Ina May Gaskin* from film makers Ricki Lake and Abby Epstein on 22 September 2011. On 18 October 2011 we are showing *More Business of Being Born: Special Deliveries*. All of our movie nights are held at Northcote Town Hall and are a fantastic opportunity to watch inspirational birth movies, hear interesting speakers and meet other people interested in birth.

Our independent childbirth education classes *Choices for Childbirth* ran in July and will run again in October. Details can be found on the Maternity Coalition website.

Choices for Childbirth ran a new workshop in July on "Moving beyond a difficult birth experience". The workshop was booked out showing a real demand for

this service. Thanks to Rhea Dempsey for facilitating the workshop. We will be running another workshop later in 2011. You can register your interest in this by contacting Jess at northcotechoices@maternitycoalition.org.au.

We continue to receive invitations to speak to midwifery students about the work of Maternity Coalition and consumer issues in maternity care. Ann Catchlove spoke in August to students at RMIT. We have also been asked to participate in the Australian Catholic University's Midwifery Course Review.

Ann Catchlove met with Catherine King in August. Catherine is the Federal Parliamentary Secretary for Health and Ageing and the Victorian member of a Labor party caucus committee looking at issues around the (extended) insurance

exemption for midwives attending homebirths.


Maternity Coalition Victoria is also participating in the reference group for the "statewide framework for private practice rights for Registered Midwives in Victorian public health services". We look forward to hopefully seeing some meaningful progress towards the Commonwealth maternity reforms actually delivering a new choice for birthing women in Victoria.

As always we are very keen to welcome new committee members and new ideas. Please don't hesitate to contact me on vicpresident@maternitycoalition.org.au to discuss how you might get involved or to let me know about any issues that you think we should be addressing.

Maternity Coalition Movie Night

FROM EXECUTIVE PRODUCER **RICKI LAKE**
AND FROM DIRECTOR **ABBY EPSTEIN**

MORE BUSINESS OF BEING BORN




THE MUST-SEE MOVIE GIVES BIRTH AGAIN
morebusinessofbeingborn.com

Guest Speaker:
Rhea Dempsey
Birth Attendant, Childbirth Educator, Councilor and mother of 3

Date: Tue, 18th October, 2011	For bookings:
Time: 7:00pm	Email: MCmovie@birthattendants.info
Venue: Northcote Town Hall 189 High St, Northcote	Phone: 03 8677 1881
	Web: www.birthattendants.info

Cost: \$10 pre-paid booking, \$15 at the door

Brought to you by:  **Maternity Coalition** and [Birth Attendants.info](http://BirthAttendants.info)

2011 AGM

2011 Annual General Meeting - Change of Date

Saturday 22 October 2011

Time: 4 pm Eastern Daylight Saving Time

The Annual General Meeting (AGM) will be conducted via conference call. Members who wish to arrange a connection to the meeting, or submit nominations for a committee position please contact

Secretary Georgia Hodges secretary@maternitycoalition.org.au

The business of the AGM is to:

- confirm the minutes of the preceding AGM,
- receive from the Committee reports upon the transactions of the Association during the preceding financial year, and
- declare all committee positions vacant and elect office bearers and committee members of the Association.

All members are invited to join in the AGM.

Please consider how you can support the ongoing work of MC by assisting or nominating to fill one of the committee or office bearer roles.

The management team has been developing a system of mentoring members. We would warmly welcome people to participate in the Committee in an assistant role. This means you learn the ropes as you go, building on the knowledge of existing committee members. The aim is to make the transition to a new committee as successful and smooth as possible.

Below is a quick outline of key responsibilities for each position. Please contact the Secretary for more information or to nominate for a position.

President: provides leadership, usually chairs meetings, in consultation with the Secretary, ensure that notices / minutes of meetings are distributed to members in a timely and appropriate fashion and acts as the spokesperson on behalf of the MC. Provides reports to the Committee quarterly on action and representation during the preceding quarter.

Vice President: assists in leading the organisation, fills in for President as chair and spokesperson. Liaises with committee members, branch presidents, currently responsible for social network site.

Secretary: is the principal administrative officer and needs to make and keep a correct record of all proceedings and resolutions at meetings, including the names of those present and those who tendered apologies, distribute minutes to members of the committee, oversee preparation for and notice of meetings, assist other officers with the preparation of reports for the AGM. Communication with the committee shall be, wherever possible, by electronic mail.

Treasurer: to collect and receive all monies due to the MC, to make all payments authorised by MC, to keep correct accounts and books showing the financial affairs of MC with full details of all receipts and expenditure connected with the activities of MC, provide a quarterly profit and loss statement and organise audit of the finances of MC.

General Committee Members: assist with specific actions arising from meetings. Take on specific projects to develop the organisation.

Membership Secretary: responsibilities include send out renewal reminders, provide annual summary of membership, process and update membership requests, and receipt membership payments and post to recipient.

Current Management Team

Office Bearers

President: Sarah Kerr

Vice President: Makayla McIntosh

Secretary: Georgia Hodges

Treasurer: Naomi Campanale

Assistant Treasurer: Jo Askham

General Committee Members

Bruce Teakle

Nicole Carver

Membership Secretary

Bec Telfer

Birth Matters Editorial Team

Kylie Sheffield (Editor)

Sonia Bartoluzzi (Assistant Editor)

Mara Dower (Design and layout)

Bec Telfer (Distribution)

New miscarriage anthology breaks the silence

By Kylie Sheffield

When someone we know miscarries, most of us don't know what to say. So, we do one of two things. We offer up what we think is a silver lining – *at least you already have two healthy children... at least you weren't too far along yet... at least you can try again...* – or, we say nothing at all. Misunderstood and abandoned, even by those closest to them, women have typically been expected to grieve quietly and alone, recover quickly and emerge unscathed from an experience many perceive to be little more than an unpleasant but temporary health glitch.

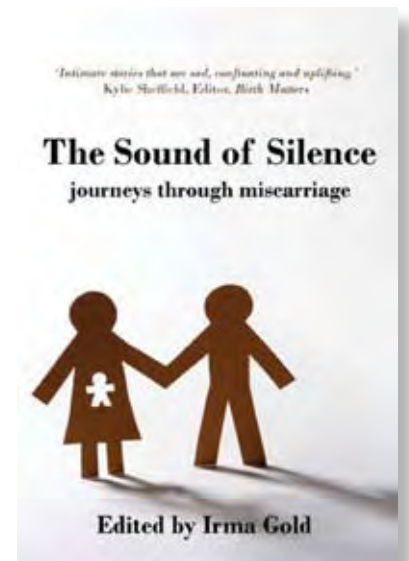
The twenty-two voices in *The Sound of Silence* lift the taboo that has, for too long, been condoned as an unavoidable effect of losing a baby in early pregnancy, and

carry the clear and crucial message that, for a mother, a baby's life begins long before it breathes its first. These women share with us their most intimate moments in stories that are at once sad, confronting and uplifting. In return they ask only that we bear witness and, in doing so, acknowledge the realness of these beings we will never see, hear or touch and the deep and abiding love of those to whom they are lost but will never be forgotten.

A full review of *The Sound of Silence* will appear in the Summer edition of *Birth Matters*.

For more information:

<http://www.youtube.com/watch?v=tQXM1bqywO0> <http://www.mostlyformothers.com/miscarriage.html>



ARE YOU A MULTI-TASKER?

WANTED: Passionate people to join our editorial team

We are looking for people to join our editorial team later in 2011. If you have experience in the areas of writing, proof reading, editing or design and layout (or have the time and motivation to learn) and feel passionate about the need for an accurate and representative voice on the Australian birthing scene, we'd love to hear from you.

Email birthmatters@maternitycoalition.org.au or call **Kylie** on **0414 494 853** for a detailed role description or more information.

BIRTH MATTERS IS CHANGING

It's important to us that we bring you a journal that represents the experiences of ALL women and accurately describes the developments and politics of birth in Australia.

- Themes will be announced two to three issues in advance and advertised on our Facebook page.
- We'll endeavour to keep up with what's happening on Facebook and relevant blogs so we can best reflect a broad cross-section of views and attitudes.
- Every edition will include a Federal Update so you know what's happening nationally, what MC is doing about it and what you can do to help.
- We're introducing a section for reader feedback—you can email us or send us a letter to comment on the content of the journal, suggest themes or share your thoughts about anything birth related.

How YOU can help

- Make the deadline! We understand how hard it can be, but we hope the advance notice of future themes will help.
- Keep your eyes and ears open. You don't have to be a Maternity Coalition member or birth reform activist to submit to Birth Matters. Do you know of someone who has a great story to share or is well placed to submit a relevant article? All we need is a name and contact details. We'll do the rest.
- Tell us what you're doing. MC News is a great place to share what's going on in your area. Keep the news coming in.
- Stay in touch. Send us your comments, suggestions and concerns. We care what you think, so let us know.

Email birthmatters@maternitycoalition.org.au or call Kylie on 0414 494 853.

We look forward to your ongoing support as we work to make *Birth Matters* the most current, accurate and representative voice on the Australian birthing scene.

BIRTH AFTER CAESAREAN SUPPORT: ONE ORGANISATION'S OFFERING

It can be hard to find evidence-based information and caring support when beginning the journey towards another birth after caesarean. One organisation working to change that is Brisbane-based Birthtalk™, co-founders of the Caesarean Awareness Network Australia (CANA).

Women birthing after a previous caesarean often have special needs and considerations. There may be issues surrounding whether to have a repeat caesarean, or a vaginal birth after caesarean (VBAC). There may be relevant emotional issues surrounding 'what happened' last time that need to be addressed. And it can, at times, be difficult to access evidence-based information and support that would help in decision making and processing of options. Brisbane's Birthtalk runs Australia's only eight-session VBAC Course, which includes information about both VBAC and empowered birth after caesarean (EBAC). Birthtalk also offers support and understanding in issues surrounding healing from a previous birth.

Knowledge Not Fear

Birthtalk acknowledges that women and couples planning a subsequent birth after caesarean do have some specific issues to consider. Birthtalk encourages attendees to approach these issues in the context of working towards an empowering birth, where you are making all your decisions based on knowledge, not fear. The course enables those preparing for a birth after caesarean to receive evidence-based information, and offers appropriate support so attendees can ask questions and have their fears addressed.

Won't a VBAC Just Be Better?

Many women initially assume that having a VBAC will make their birth a positive event. At Birthtalk we are often asked, "Surely a vaginal birth will just be better anyway?" Unfortunately, many of the things that can make a caesarean such a traumatic way to meet your baby are not restricted to caesarean birth. These things include feeling out of control of your birth, feeling ignored or abandoned, feeling fear or confusion, or feeling unable to ask questions. While having a caesarean can increase the possibility of these feelings occurring (simply due to it being surgery, where you are immediately more vulnerable), having a vaginal birth in no way protects you or eliminates the possibility of feeling this way.

Empowering and Safe

According to Birthtalk, to make your birth a positive event, you need to focus on having an empowering experience. The above list of traumatic feelings is, in essence, the definition of a disempowered birth. All women want their VBAC to be an empowering and safe experience, so, it makes sense to focus on turning the above feelings on their head. This means learning tools and accessing information so you feel: in control of what happens to you, central to the experience, safe and nurtured, and able to obtain information through questioning your care-givers. This will increase the possibility of walking away from your birth feeling strong, confident, and positive about the parenting journey ahead. Birthtalk offers these tools and other ideas at their VBAC course. ©Birthtalk2009

One of the best ways you can support birth reform is to...

ADVERTISE IN BIRTH MATTERS



Our readers are passionate about birth, babies and making informed choices. If you want to reach savvy, informed mums-to-be, midwives and doulas, have a business that fits with MC's philosophy and want to support the campaign for improved maternity services, contact:

birthmatters@maternitycoalition.org.au

Our advertising sponsorship packages start from as little as \$50 an issue for a business card size ad. We also offer full colour advertising on our inside and back covers. If you sponsor us for 12 months, we'll promote your business on the MC website, at Choices for Childbirth sessions and through our events, support group and branch meetings.

Birth Matters is distributed in hard copy to approximately 700 members (including approx. 20 organisations with their own membership bases) nation wide and is available online via the Maternity Coalition website as a PDF (online complete issue in full colour).

Member notices

Management committee meetings (National)

The committee meets monthly, or as required, via telephone conference call. Dates and times have been set to optimise the involvement of members who are separated by great distances and time zones. All members are welcome at these meetings. and are advised to contact secretary@maternitycoalition.org.au for details. Communication between meetings is mainly by email.

General meeting dates for 2011

General meetings will be called as required, and members given 14 days notice. The date for 2011's AGM on Saturday 8th October, 2011, 3 pm EST. Full AGM details on page 7.

Midwives in Private Practice (Victoria)

MIPP is a participating organisation of MC. To request a MIPP brochure, or for other information including membership inquiries please email mipps@maternitycoalition.org.au. MIPP meetings are held monthly. Midwifery students who are members of MC are welcome at MIPP activities.

Choices Victoria

For details and dates regarding Melbourne, Geelong and Ballarat Choices for Childbirth programs, please visit our website: www.choicesforchildbirth.org.au.

Donations

MC thanks you for your generosity to our organisation. Your donations fund our important work and help us to get one step closer to reform of Australia's maternity services.

MC's book keeper, Meredith, would like to request that any donations made by members be accompanied by an email to accounts@maternitycoalition.org.au to let Meredith know the amount that has been deposited into the bank account and the reference. This is so she can make sure funds are allocated to the appropriate sub-accounts.

MC bank account details

Commonwealth Bank of Australia Branch: Ringwood Victoria

Account Name:

Maternity Coalition Inc.

BSB: 063 167

Account Number: 10108586

Postal Address:

PO Box 1190 Blackburn North
Victoria, 3130, Australia

Infosheets

The Maternity Information Initiative was established in 2006 to "develop a series of consumer information sheets on key maternity topics." Infosheets are designed to assist women to question and communicate with their care givers, and make informed decisions in their maternity care. This will help ensure that care offered is appropriate for the woman, her pregnancy, her goals and individual circumstances. Infosheets are available on our website to download free of charge.

Topics include:

- A healthy pelvic floor after childbirth
- The third stage of labour
- Pre-labour rupture of the membranes
- Induction of labour
- Births after caesarean
- Labour in water
- Bearing down or directed pushing?
- "Who cares?" Choosing a model of care
- A baby's transition from the womb to the outside world
- Preparing your birth plan
- Breech birth

Birth announcements note

It is our policy not to publish the names of homebirth midwives due to the current situation in which these midwives work. Homebirth midwives have no insurance and are often targeted by regulatory authorities despite providing excellent care.

As such we feel it is our duty to support those midwives that continue to provide care for women who want the opportunity to birth at home with a trained professional by respecting their need for privacy.

If you want to name your midwife in your birth announcement or birth story, you first need to seek their consent to have their name published. Once you provide written consent from your midwife, we will publish their name if you desire.

MC online discussion lists and social networking groups

Join an MC email group!

MC members are able to keep in touch with other members interested in the same issues via Yahoo! email discussion groups. Yahoo! Groups allows files to be stored and retrieved including documents, databases and the like, and messages archived. All discussion groups are governed by electronic communication guidelines established by the MC National Committee.

Maternity Coalition on facebook. There are several birth-related facebook groups. If you are a member of facebook you can join any of the following MC-related groups: The Maternity Coalition Inc., Caesarean Awareness Network Australia, and *Birth Matters Journal*. There are also several branch groups. Jump online and explore!

OZBIRTHING. An open group that can be joined (or unsubscribed to) via the maternitycoalition.org.au website. Just log on and follow the prompts!

MCNSW. For NSW members and other interested individuals. For an invitation to join, please contact Carol Chapman dean50@ozemail.com.au or Lisa Metcalfe at nsw@maternitycoalition.org.au.

MatCoWA. For members in WA. Contact Tracey Reibel at wa@maternitycoalition.org.au if you'd like to join.

MCmidwives. For midwives, midwifery students and others who are members of MC who are committed to seeing woman-centred birthing in Australia become a reality for the majority of women. To join contact Joy Johnston at joy@aitex.com.au.

BAClist. A discussion and action group dedicated to issues, media and research about birth after caesarean and caesarean surgery. It is moderated by Caesarean Awareness Network Australia representatives. Contact info@canaustralia.net to join.

Qldcore list is for active members of Maternity Coalition in Queensland. Queensland also has two other lists if you don't want to join the core group but want to stay informed or receive a copy of the Birth Action News e-newsletter. Contact qldpresident@maternitycoalition.org.au.

Find us on



Maternity Coalition Contacts

MC contacts (National)

Office Bearers 2011

President: Sarah Kerr
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Assistant Secretary: Vacant

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Assistant Treasurer: Jo Askham

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Assistant Birth Matters Editor:
Sonia Bartoluzzi

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Bruce Teakle
Kylie Nicholson

Other really important people who support our National Management Committee

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National Peer Support Advisor: Alison Gaffney

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teakle@maternitycoalition.org.au

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Branch contacts

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Geelong President:

Cherie Nixon
Geelong MC/Choices for Childbirth
0423 189 317
geelong@maternitycoalition.org.au

Ballarat President: Michelle McRitchie
ballarat@maternitycoalition.org.au

Branch Information

If you wish to become active in MC and there is no branch near you, contact the President or a member of the national Management Committee, who will assist you in setting up your local branch. Branches and participating organisations may be formed in any state and territory of Australia, or in any location that is identified by a group of at least five (5) members.

There may be more than one branch formed in each state or territory.

A branch may be formed upon the authority of the Management Committee. A branch of the organisation is independent of other branches in its activities and fundraising. For details of financial arrangements including reimbursement of costs upon presentation of receipts, contact the Treasurer.

Terms of Reference of each branch are to be consistent with those of the Maternity Coalition.

Find us on 

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A **personal voice** rarely heard in discussions about maternity services, **Birth Matters** is a forum for debate and discussion about the issues that affect birthing women and care providers in Australia.

Want Extras?

Extra single copies of *Birth Matters* are available for \$10 including postage and handling.

For bulk orders (500g or more), please contact the Editor for rates. birthmatters@maternitycoalition.org.au.

Simply visit our website at:
www.maternitycoalition.org.au
and subscribe online to reduce carbon emissions

Or write to:
PO Box 1190
Blackburn North Vic 3130
to request a brochure.



☐ Yes, I'd like ____ membership brochures for Maternity Coalition

Please send brochures to/contact me via:

Name: _____

Organisation (if applicable): _____

Street/PO Box: _____ Suburb/City: _____

State: _____ Postcode: _____ Country: _____

Telephone: _____ Email: _____

A PDF of the brochure can be emailed upon request. Contact secretary@maternitycoalition.org.au



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