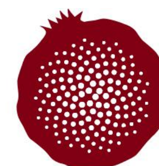

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22 June 2014

Submission to the Draft Revised
Safety and Quality Framework, June 2014

Thank you for the opportunity to provide feedback on the Draft revised Safety and Quality Framework (SQF) for midwives.

I am a privately practicing midwife in Southern Tasmania, providing mostly homebirth services. I have been notated as an Eligible Midwife since Nov 2011 and obtained my prescribing rights in early 2013.

I particularly appreciate that this draft of the SQF is directed at the practice of all midwives, as I feel as a midwife in private practice, my practice responsibilities are not essentially different to midwives who are employed by public or private health services. I believe it is a core principle to keep in mind, that a midwife is a midwife is a midwife, no matter where he or she practices and the inclusion of the ICM definition of a midwife at the very beginning of the document is commendable in ensuring it remains central to our dialogue around midwifery.

I also applaud the reference to the practice of midwifery as a partnership with women and their families and making more reference to this core principle throughout the document, rather than only at the beginning, would be more meaningful. I would like to see this section taken further to include the right of “informed refusal” alongside choice and consent and to look at changing the wording of some listed principles in under this section. For example, using the phrase “individual negotiation” could infer that a woman’s right to decide all aspects of her care is not absolute and instead what she wants, even if fully informed, needs to be “negotiated” with her caregivers, implying compromise on her part.

Similarly, it would be prudent to recognise that in listening to advice from caregivers and gathering information about her situation, women make decisions about their health care and in so doing, take responsibility for it. Simply listing “shared responsibility” is not clear or helpful: shared with whom, and to what degree? I believe it is important to emphasise the rights of women as autonomous decision makers regarding health care decisions about their own bodies and their babies. Midwives can only provide advice and support to women in making their decisions and do not have any “final say” or place to “negotiate”. It also follows that midwives have the right to decline to care for a woman where her choices place the midwife outside of her scope of practice, depth of experience or indeed ethical beliefs. This is not to suggest it is acceptable to abandon a woman in labour or any urgent situation because of a choice she makes.

In addressing the section on Indemnity Insurance, it does of course remain a critical issue that no insurance product includes cover for planned homebirth and I know the Board has considered this

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and continues to search for a solution. I believe the solution is a public pooled fund, similar to our Motor Vehicle Accident and Insurance scheme, which enables families affected by birth injury to access money from a public fund. This takes the onus off families having to prove negligence of a caregiver, where none may even exist, to access any provision of funds. It does not, of course, in any way, prevent a woman for suing for negligence or malpractice. As you are aware, this was the path taken in New Zealand and the action then enabled the midwifery college to indemnify its members.

I remain deeply concerned about the effect of mandatory reporting, particularly with what can only be described as vexatious reporting against midwives in private practice. I would urge the board to consider ways to protect against individuals making reports which cannot be reasonably substantiated by evidence or are concerning trivial matters which have not placed individuals in harm's road. I refer to one report known to me where hospital staff reported a midwife in private practice for requesting a woman have a Caesarean "in the lotus position". Clearly a misinterpretation and in any case not an incident requiring reporting! There are countless other examples as you are no doubt aware. While I support mandatory reporting there needs to be a process of dismissing reports which are not about a serious departure from professional standards or regarding an incident where no harm has come to any person. An education campaign about what constitutes appropriate grounds for making a report would go some way to addressing this serious issue, which places incredible stress on midwives who are notified as well as wasting large amounts of public money. It is very concerning that there is no support for midwives in the process of facing a report against them and their level of distress is unbearably high. In several instances I've known midwives dealing with suicidal thoughts during this process, even though it is clear to me they have given only excellent midwifery care in the incident. I urge the Board to look at revising the process so it becomes a supportive exercise and not a punitive one, as is the case in the New Zealand model. This can still fulfil the function of protecting the public while ensuring there is support provided to these midwives.

Regarding the sections which pertain to Consultation and Referral and Collaborative Arrangements, I believe reform is desperately needed in this area. I do commend the change in legislation which allows midwives to have a Collaborative Arrangement with an entity as it is one small step away from a system where PPMs are dependent on the goodwill of an individual medical practitioner to access the MBS. However, the deeper question is what message it sends that PPMs as a group are legislated to have such arrangements. All midwives, PPMs included, are already regulated to consult, refer and transfer care where a woman's needs fall outside of the midwives scope of practice and to require PPMs to enter into these "Collaborative Arrangements" as specified in the law, is to single out and demean this group. Furthermore these "Collaborative Arrangements" do not offer secure pathway for consultation and referral as originally intended. PPMs have always sought to consult and refer women where needed and the pathways they have always used – the local hospital maternity triage, a known medical colleague or the woman's GP – continue separate to the Collaborative Arrangement the woman has on paper. In fact, requiring the woman to get a referral from her GP or seduce a hospital to answer a request for collaboration places an unfair burden on women and midwives and is not useful in actual practice. For example, I often use the GP referral option for a Collaborative Arrangement as this is the easiest to obtain, but most often where a woman has a need for consultation or referral, it is not this GP who is the appropriate source to go to, but the hospital where she is booked in for back-up or the Obstetrician who has agreed to back up for her verbally but would never agree to a formal Collaborative Arrangement. These

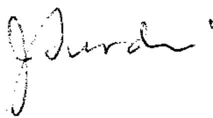
requirements hinder real collaboration rather than help it. I'm aware that this is a matter for legal reform and not directly under the control of the NMBA, but I raise it with you regardless so that in lobbying government we can work together for appropriate reform.

Regarding the standards for Eligibility, another area I would like to see change is the concept that Eligibility is a separate class of midwifery, further to and above being a registered midwife. This is not the case in Medicine, where access to the MBS is part of being registered in the profession after a short timeframe. I believe it undermines the scope of midwifery practice to create a separate "class" of midwives and in my view the MBS should be available to any midwife and the caveats of Peer Review, additional CPD and recency of practice should not create a separate category of registration. I would support the MBS being available to new midwifery graduates if it is under a supportive mentorship program. If the standard for registration alone does not make a midwife a professional, responsible and safe practitioner, then it is that standard which needs to be raised and not an additional "advanced" class of registration which needs to be created. I would further suggest that the prescribing courses offered as Graduate Certificate currently, should be part of an undergraduate Midwifery Bachelor or Diploma degree, as is the case in other countries' midwifery education.

I note that there is currently no form of support or mentorship for midwives who are new prescribers. This is a matter which I've found difficult in my practice and that perhaps the Board could raise with the ACM. A program of mentorship is needed where a new prescriber can ask informal questions of experienced prescribers, where resources are not available or clear cut and where a formal consultation is not warranted. I believe this is a significant need to make new midwifery prescribers safe and it is something our medical colleagues have always arranged for. As you've noted, PPMs can often feel isolated and avenues for advice can be limited, or rely on the goodwill of friendships with otherwise busy medical colleagues.

Thank you again for the opportunity to comment on the Framework which will directly affect my practice. I appreciate all the work the Board has done in revising the Framework. Please don't hesitate to contact me for any clarification of any part of this submission.

Yours sincerely,



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