T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bendigo — 24 October 2017

Members

Mr Paul Edbrooke — Chair
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Witnesses

Ms Elizabeth Murphy, midwife,
Ms Marie-Louise Lapeyre, midwife,
Ms Samantha Ward, midwife, and
Dr Veronica Moule, collaborative partner, Midwife Collective.

The DEPUTY CHAIR — I welcome to these public hearings Ms Elizabeth Murphy, midwife, and Ms Marie-Louise Lapeyre, midwife, from the Midwife Collective. They are joined by Samantha Ward and Dr Veronica Moule, also from the Midwife Collective — or not?

Dr MOULE — Sam is; I am a collaborative partner with the Midwife Collective.

The DEPUTY CHAIR — Could I ask Dr Veronica Moule to clarify her relationship with the collective?

Dr MOULE — Yes, certainly. The submission that we put in we put in together as a group of four. As you can see, all of our names are at the base of the submission.

The DEPUTY CHAIR — All right; we will continue. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is in contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof of the copy of the transcript. I invite you to make up to a 15-minute statement, followed by questions from ourselves. We have allocated half an hour.

Ms WARD — Thank you. We would like to start by acknowledging the traditional owners of the land on which we meet. We predominantly work south of here on the lands of the Dja Dja Wurrung people. My name is Samantha Ward and I am a registered nurse and midwife and part of the Midwife Collective. I would like to address women-centred care in a maternity systems care model. How is it truly possible to provide women-centred care in Australia's maternity settings that are built on systemised, technocratic, autocratic, industrialised systems stemming from Fordism, the factory process line circa the 1890s? One might be cynical and call it false advertising aimed at conning and coercing women who question or stray too far from the conventionalised processes of birth.

Standard maternity care today has so many systems, standardised processes, checkpoints and flowcharts that you can hardly see the woman anymore, let alone hear her. It needs to be this way because the system is faulty, outdated and under constant pressure. It would not be uncommon for a woman to come into contact with over 50 different staff members during the course of her pregnancy care. How is any woman the centre of her care? Maternity care has become a system driven by fear and lack of knowledge and skill in how to best support birthing women in an environment that is artificially constructed, not naturally conducive to birth. There have been many decades of convincing women that the medicalisation of birth is good and is safe and that believing is becoming a cultural norm. Maternity care facilities are now filled with high-tech equipment with limited accuracy that oppose everything natural to birth, that invade the mother and the unborn in an attempt to reassure the system all is well, because the system will not listen to the mother.

There has been much investment in increasing technical skills, and virtually none in the fundamental act of being with woman. It sounds easy yet it is nearly totally absent in standard maternity care. Midwifery has always been about being with women and always will be. Women when in childbirth want women with them, preferably being nice to them, keeping a calm and watchful eye on them, keeping them and their unborn safe, and knowing when to call for assistance, because midwives know what normal birthing women look like, sound like and act like. The ideal is for women to give birth in their local community and only transfer to a larger centre if complications arise, accessing a high level of care as required. Continuity of care in a local setting is the model of care that provides the best outcomes for mother and baby in terms of both birthing morbidity and psychological wellbeing post-birth — keeping birth normal, keeping mothers with their babies, high breastfeeding rates and babies breastfeeding for longer. It is well reported that continuity of care models provide the most satisfying maternity experience with the least amount of intervention.

I would like to talk about accessing continuity of care. You have heard some of that earlier on with Bendigo Health, so I would just like to expand on that a little bit. The Mount Alexander shire currently has this model with three GP obstetricians providing continuity of care in birthing through Castlemaine Health, with approximately 50 to 60 births a year. However, maternity services relying solely on GP obstetricians is unsustainable, as demonstrated by many birthing services in rural areas closing. The rural medical workforce is coming to a crisis point. Private midwifery services, which is what the Midwife Collective is about, provide continuity of care services and are available within the Shire of Mount Alexander, the City of Greater Bendigo, and occasionally through the City of Ballarat and through the Shire of Hepburn.

Private midwives offer the full scope of midwifery care, including birthing in the woman's home. There are currently no private midwives with admitting rights to hospitals in these regions. This model is cost prohibitive to many women and is income prohibitive to many midwives wishing to provide this service. Interestingly, private midwifery costs are approximately the same as vaginal birth costs in a hospital and less than half the cost of a caesarean section. Private midwifery in this country is critically endangered. It is undervalued, undersupported and actively threatened.

Bendigo Health offer a continuity of care model with the MAMTA program, as you have previously heard. This model has been highly successful, and, as you have heard, it gets a lot more applicants than what it is actually able to provide the care for. Many women in our area miss out on the pregnancy care model they want because it is either not available or it is cost prohibitive.

How to futureproof maternity services? Midwives are the specialists in normal birth. There will always be more midwives than obstetricians. In our opinion the change that will futureproof maternity services is to extensively expand localised midwifery-led care to all women, enhanced by specialist care provided as clinically indicated. This is not a new concept. It is the change that many services have expanded to across the country because of the lower costs and the better outcomes.

Ms MURPHY — I have prepared a statement. I was not quite sure about the way this was going so I hope this is okay.

When the human baby is born it is a vulnerable and immature mammal. It has instincts and abilities to help it to survive, but relies on those around it, and particularly its mother, to care for and feed it. It is exquisitely sensitive, and the imprints of its first hours, days and weeks are lifelong. Women who have a positive birth experience are empowered and elated by the birth of their babies. In giving birth they will have experienced the strength of their own bodies. They will have been part of their own personal miracle. Women want to give birth naturally — that is a research-based statement. It is not a romantic or biased opinion; it is the answer that women give when they ask if they would prefer to have various interventions such as planned caesarean or epidural induction, or give birth naturally.

In 1985 the caesarean rate in Victoria was 15 per cent. The latest available figures show that in 2015 it is 33.4 per cent, with another 15 per cent of women having an instrumental birth and 44 per cent of women have their labour either induced or augmented artificially. Women in private hospitals have a caesarean rate of 42 per cent — this despite having a higher socio-economic standard with consequent better health.

Women's bodies have birthed the human race. Women's bodies have given birth to the whole of humanity for the whole of human histories. Our bodies work. Our bodies must work or else the human population would not be growing as it is. There has been no physiological change in women's bodies to warrant the escalation in interventions during birth that are now so prevalent.

Women want to give birth naturally with someone they know caring for them. Lots of research, including the COSMOS study at the Royal Women's Hospital, has shown that women have a much better chance of a natural birth when they are cared for by someone they know and trust. Women want privacy, warmth, respect, caring and support through their labour, birth and postnatally. The hormonal physiology of childbirth study has collected and collated vast amounts of research that shows that women are more likely to have a natural birth with better outcomes for both mother and baby when they are given privacy, treated with kindness and feel warm, safe and supported in labour.

These are simple requests. They sound like human rights: the chance to make personal decisions about one's own body, privacy when performing bodily functions, personal choice about who will be with you during intimate activity, safety, respect and self-determination. Some women do not want to accept the standard care package that is provided to them during pregnancy, labour and birth. Women have a right to refuse the care that is offered. Women expect to be taken seriously and respected when they make these choices. The care that is offered is not all scientifically proven as necessary or sometimes even best practice.

Maternity care is often ritualised, with standard practices that interfere with the natural working of the body and slow, halt or inhibit the normal progress of labour. It is difficult to compare birth to other human functions. It is more momentous, more important and more challenging than other parts of the day-to-day life. It is perhaps useful to propose some other scenarios to think about how we treat women in birth. Would we offer a marathon

runner some strong analgesia or a wheelchair as they rounded the bend, puffing furiously, muscles aching as they powered toward the finish line just a few kilometres away? Would conception work better if properly trained specialists took observations, made comments and suggested position changes? Would it be safer if we hired paediatricians for all our babysitting?

These questions seem frivolous, but it is obvious that the interventions mentioned would result in unnecessary and unpalatable outcomes. The care of women is being supervised, watched and measured during a normal physiological process by experts in abnormal physiology. Consequently normal women are treated as if they are abnormal, and their opportunity to achieve a normal pregnancy and birth with the consequent benefits is greatly reduced.

Vaginal examinations are performed without proper consent. Women are coerced into having painful examinations that they do not want and they do not often need. Water immersion in labour and during birth is very soothing, analgesic, relaxing and safe. Women want to be able to birth in water, and in this region they are denied this choice. Third stage is sometimes treated as a medical emergency, the natural flow of protective hormones is interrupted, and women have their placentas chemically and mechanically removed. This does not result in any safer outcome. Victoria reports a postpartum haemorrhage rate of 25 per cent.

Women are not saying, 'I don't want blood tests because I hate blood tests, or ultrasounds or vaginal examinations'. They are saying, 'I don't need your blood test to tell me I'm okay.'. This is not someone who is actively rejecting antenatal care. This is someone who knows her own body and views her life, her health, through a different and legitimate lens.

We do not need to rely on science to prove that kindness and gentleness are beneficial, but science is nonetheless showing this — and we even have an explanation for the chemistry. In birth oxytocin, the so-called hormone of love, causes the uterus to contract, and after the baby is born it pumps out and the woman is able to birth her placenta safely. At the same time both she and the baby respond and connect deeply. Fear decreases the action of oxytocin by increasing the production of adrenaline and cortisol, the flight and fight hormones. Flight and fight are not conducive to an efficient labour or birth.

Yes, birth is a challenging process that benefits from support, but support can also come from midwives who are trained in recognising normal, who are familiar with the challenges women face and can offer educated reassurance and advice when necessary. Women are then able to be held within the love and support of their nearest and dearest and discover their inner core of strength and resilience. If only birthing women everywhere had support and faith surrounding them so that they could find their strength, knowing that women do not need rescuing, and the world could be rightfully in awe of mothers.

How you are born is important. It is important for humanity. It is important for our species. How we treat women in labour affects their relationship with their babies and colours that ongoing relationship. Families should not be traumatised by birth.

The DEPUTY CHAIR — Thank you. We have got some questions now.

Dr MOULE — Can I present mine or part?

The DEPUTY CHAIR — That will cut in on our question time. Will it be quick?

Dr MOULE — Yes. There is a continual shift in birthing services to increasing intervention. That is what the statistics say. That is what women who come to debrief their birth experience say. We are losing any sense of risk tolerance. The more risk averse we become, the less patient autonomy. For some women this is fine. There are women who want to absent themselves from labour. They call for an epidural early, and they are well catered for in the public and private sectors. Victoria's current epidural rate is 40 per cent. For women who do not want to absent themselves, women who want to be present for this astonishing experience of labour, the biggest event of their life, how do we support them? They do not want to slip into the intervention model for no good reason. They do have opinions about how they want their care. They have their own personal philosophies, religious or spiritual. They have their own emotional challenges that make them bold or anxious or angry or passive or stubborn, and this can make it difficult as a birth attendant — difficult to reach them for their emotional needs, difficult to understand where they are coming from. Truly respecting patients' choice means that sometimes we as birth attendants need to sit in difficult and uncomfortable places.

There is a vulnerability as birth attendants. We practise simulated scenarios of obstetric emergencies, but we do not really want to do these in real situations. It is not until we face these clinical situations that we find out what our capacity is. We hope, but we do not know, if we will be calm and mature and follow the protocol from memory, or we have had these experiences and we could not overcome our fear, somebody else stepped into our place or the outcome was poor and we fear this ever happening again, so we tolerate less risk in the next woman.

And we are searching for risk factors — searching with tools that are not very accurate, and then we are believing these inaccurate tools. We are being risk averse. If we are clever, we might find something before it would present itself clinically, and the earlier things are modified, the earlier interventions are put in place. This is happening in pregnancy well before labour starts. In fact the minority of women have a baby start with spontaneous labour.

And there is all this intervention going on, and women have almost no say in whether they participate, because if they do not, they will be labelled difficult patients. Hospitals like obedient patients. Hospitals do not like disobedient or difficult patients. They make you feel naughty if you do not agree with what they are recommending. Hospitals express this as though the patient has opened an emotional wound in the hospital staff by disagreeing, by women asking for something that is deeply important to them.

Then these women avoid coming in, they wait until the last minute and they present us with the florid clinical situations that we did not want to deal with, because they feel marginalised. We need to offer health care to these marginalised women. We need to find the way to make them feel some level of safety. The way intervention rates are going, marginalised women are not just those the hospital thinks are extreme. Now any woman wanting to have a truly natural birth without unnecessary intervention is a marginalised woman.

The less we allow women's autonomy and the more interventions we put in place earlier as clinicians, our internal goalposts start to modify. Our sense of the breadth of normal reduces, because we do not allow the same breadth within normal, and we are running towards risk aversion with minimal tolerance of any risk and no room for women's decision-making, for women to have a sense of their capability, for women to have allowed themselves to stretch to their own breadth of capacity, stretch themselves physically and emotionally unravel themselves to their depths, to the raw openness physically, emotionally and biochemically that our biology is designed for, that allows the overwhelming wonder of the mother receiving her child for the first time, receiving her child from herself, from within her own body on a hormonal and cellular level that primes the mother-baby unit for the rest of their life together. And we cannot see what we are losing as we run towards this risk aversion model of care.

The DEPUTY CHAIR — Thank you. We have got a series of questions now, but if we could be quite succinct because we have cut into our time a little bit. I would like to start by asking about the process of engaging a private midwife. How does that normally happen? How many appointments would you have ante, during, post? What is the cost associated with each step?

Ms MURPHY — Women find us often through Facebook or from personal recommendation. We do have a website. The process is women will contact me and we will have a conversation. I will usually go to their house and discuss the process of how we care for people during labour, pregnancy and postnatally.

The DEPUTY CHAIR — There is no charge for that?

Ms MURPHY — There is no charge for the initial visit. If they decide that they want to engage me or my colleagues as a private midwife, then they are encouraged to get a referral to us from a GP, because in order to get Medicare rebates, that is what they need to do. Also for insurance purposes we need to have a referral from a GP. Then when they have done that they get back in contact again and we start the pregnancy journey. Women have eight to 10 visits usually, depending on what they need. All the women that I have cared for so far have started off their pregnancy in a low-risk kind of way. I am not looking after twins and things like that. Then we make a backup booking — or encourage the women to make a backup booking — at the appropriate hospital, which for our service is usually Bendigo. When it is time for them to go into labour, I am on call for them, or whoever the primary midwife is is on call for them, from the time that they engage us.

Then towards the end of the pregnancy, at around about 36 weeks, we have what we call a birth plan meeting. It is a long meeting where we discuss everything that the woman is hoping for during the birth and what her

desires are in regard to her care. We talk about what we need in regard to being able to make sure that things are safe. We talk about reasons for transfer — those sorts of things. Then when the woman is in labour she calls us. We attend her. We have to have two midwives with the woman while she is in labour and through the birth.

Postnatally we see the woman usually within 12 hours of the baby being born, and then day one, day two, day three and then as the mother requires. There are legal requirements in regard to who we tell that the woman has had the baby — births, deaths and marriages, Centrelink and the maternal and child health nurse service. We let the hospital know, let the GP know.

Because postnatal care is a fee-for-service thing, women are choosing how many postnatal care visits they want to have. We can see women up to six weeks as part of our service. Not all women want to be seen that often, so then they would get referred back to their GP or to the maternal and child health nurse, if that is what they want.

The DEPUTY CHAIR — And the costs associated with each?

Ms MURPHY — We charge women $140 for an antenatal or a postnatal visit. Those visits often take 2 hours and there is also some driving involved, because we see the women in their homes.

The DEPUTY CHAIR — They include the driving?

Ms MURPHY — Yes. And they get a Medicare rebate for the antenatal and the postnatal care.

The DEPUTY CHAIR — Of?

Ms MURPHY — I am not sure exactly. I think it is $43 for the antenatal visits and $66 for the postnatal, and I think it is $217 for the birth plan meeting. There is no Medicare rebate for the cost of the birth, and we charge $3500 for the birth. That includes the cost of both midwives.

The DEPUTY CHAIR — Okay, thank you.

Ms EDWARDS — Thanks very much for coming in today. I liked your submission in the form of a poem. It is very innovative. My last two children were born at home, so I am very familiar with homebirths.

In relation to your relationship with the hospitals here, we recently heard about the Northern Hospital pilot. Are you familiar with that? Private midwives have formed an agreement to deliver babies at the Northern Hospital. I just wondered whether your collective has gone down the path of seeking admittance rights to the maternity hospitals here, so Bendigo Health, Castlemaine Health?

Ms MURPHY — We have not.

Ms EDWARDS — And on top of that, would you be thinking around that based on the pilot? Also, what relationship do you have with the local GPs, with the local obstetricians and with the public hospitals that you potentially will end up maybe sometimes being part of birthing in the hospitals? There is your acceptance into the birthing suites, how you work with the public health system and the private health system, where you would have two hospitals. I am assuming you go to St John of God occasionally — just that relationship and how that all works, given that not all women, even though they might choose to have a homebirth, will end up having a homebirth. How does that all work?

Ms WARD — We are relatively well supported by local GPs. I am talking about the Castlemaine area in particular. Veronica is our main supporter and colleague in terms of supportive referral or discussion if we need to — consultation. We do have other GPs within the Castlemaine area that are also happy to provide that referral letter for the women and support their choice of birth. Mostly our women would have a backup booking through Bendigo Health, and we have found them to be incredibly supportive with that. Occasionally we do have to transfer, and that is pretty seamless as well.

Ms EDWARDS — Do you stay with the woman in the birthing —

Ms WARD — We can stay, but not in the capacity of a midwife, so we have no clinical involvement, clinical decision-making, with that transfer. Once the woman has had her baby or, as appropriate, if it were to be in the antenatal period, they can actually come back — they are referred back into our service as well. I would

say that within this particular region we are actually quite well supported. There are certainly regions in Victoria where private midwifery is very, very obstructed, so I consider our group to be quite fortunate with that referral service.

Ms EDWARDS — Do you have a group called Bendigo Positive Birthing?

Ms WARD — That is independent; that is not us.

Ms EDWARDS — Separate from you, okay.

Ms WARD — Elizabeth knows —

Ms MURPHY — I am a member of the Bendigo Positive Birthing group.

Ms EDWARDS — I just wondered who are the members of that group, and what do you do? If you could just briefly explain that.

Ms MURPHY — Bendigo Positive Birthing is basically a group of mothers who were — I cannot think of the word — really enthusiastic about supporting women to have a positive birth experience. There are two midwives in the group, but all the other members of the committee are not birth professionals. We run three series of three nights each year. They are kind of like antenatal classes, but not really. They are talking about ways that women can help themselves to have a positive birth experience.

Ms EDWARDS — Is there a cost for those?

Ms MURPHY — They are costing $15 a couple per night.

Ms BRITNELL — I was just wondering: are you seeing also an increase in obesity? Are you restricted from being able to work with people who have a BMI over 35? How is that sort of playing out in the group that you usually work with?

Ms MURPHY — In our group the women that approach us are all seeking homebirth. Occasionally we will get referrals for someone who wants some extra — I have not had antenatal care — postnatal care, but of the women who are seeking homebirth I would say all of them have a very health-conscious lifestyle. I actually have not had any women in the 50 women that we have looked after who have been classified as obese.

Ms WARD — We do use the Australian College of Midwives consultation and referral guidelines, and that does give us a risk assessment or a criteria selection process where, depending on what is going on for the woman, you can see whether or not it is suitable to have solely midwifery care or whether or not something has cropped up that is appropriate to either go straight to obstetrics specialist referral or whether or not you can have a consultation with another colleague and get a second opinion. So there is actually a guideline that is really well used by all private midwives to help that, and BMI would be one of those guiding factors in there.

Ms BRITNELL — Did you just say that you birth, as a group, 50 women per annum? Is that where you are at?

Ms MURPHY — No. We usually do 12 to 15 women a year.

Ms BRITNELL — Do you also work in other maternity settings so that you can keep your skill set up for —

Ms WARD — Yes, and to survive financially, because private midwifery is not a sustainable income source.

Ms BRITNELL — How many midwives are there in your —

Ms WARD — Just the three of us.

Ms LAPEYRE — I work as a second midwife.

The DEPUTY CHAIR — That is the assistant at the birth?

Ms LAPEYRE — Yes.

Ms BRITNELL — Because of the different qualifications, or what?

Ms LAPEYRE — Yes.

Ms BRITNELL — If you have a low-risk starting birth that moves into a high-risk category, do you co-manage if the person desires that, and then how does the Medicare rebate work if you are sharing care?

Ms MURPHY — We have not actually had that many women that we have needed to refer, because mostly women are healthy and well. But if someone has needed to be referred, then the reasons that we have had for referral have required someone to be admitted to hospital. Once someone is in hospital then they are cared for by the hospital and we are not clinically caring for them. When that episode of care is finished, then they can come back to us if they choose to. I would have to talk about individual cases to explain that. If you like, I can do that.

Ms BRITNELL — No, that is all right. A few years ago we saw doctors — general practitioners — being challenged by the insurance costs, which saw a lot of people dropping off from doing GP obstetrics and gynaecology. What is the insurance cost that you have to pay, and how does that determine whether you can afford to do this role? Is it a very large cost?

Ms MURPHY — The insurance cost is through one company — it is called MIGA — which is subsidised by the commonwealth government. There is no private health insurance for homebirth — there is no professional —

Ms BRITNELL — I meant professional —

Ms MURPHY — Yes, I made a mistake. There is no professional indemnity insurance for homebirth, so the Australian Health Practitioner Regulation Agency — AHPRA — has given eligible midwives an exemption from requiring professional indemnity insurance for homebirth. It is actually a worldwide problem; all over the world there is no professional indemnity insurance for homebirth. We do have professional indemnity insurance for antenatal care and postnatal care, and that costs about $3000 a year, depending on —

Ms WARD — So long as you earn under $25 000 —

Ms MURPHY — Yes, so depending on —

Ms WARD — And then it is tiered up.

Ms MURPHY — It is a bit more.

Ms BRITNELL — Overarchingly earn, not just from that profession.

Ms MURPHY — Yes, whatever. But it is tiered depending on the income that you have. It is through MIGA, which is the government-subsidised —

Ms WARD — Interestingly, though, there are two parts of the insurance. We know there is no insurance for the birth. If you do not do birth at home, the insurance is half the cost. If you do birth at home, even though there is no insurance product available for the birth episode, it is double the cost because you are doing it there. But you get no more protection, and that is tiered right through the different income brackets.

The DEPUTY CHAIR — Thank you very much, ladies, for presenting a somewhat non-conventional approach to the committee. We greatly appreciate your time.

Witnesses withdrew.