SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE
TAKEN AT BUNBURY
MONDAY, 27 NOVEMBER 2006

SESSION ONE

Members

Hon Helen Morton (Chairman)
Hon Anthony Fels
Hon Louise Pratt
Hon Sally Talbot

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Hearing commenced at 11.10 am

BENNETT, MS KARA-JANE
Spokesperson, Mothers Helping Mothers,
PO Box 1436,
Margaret River 6285, examined:

MANSFIELD, MRS SAMANTHA
Spokesperson, Busselton Birth Choices,
150 Kent Street,
Busselton 6280, examined:

TARBOTTON, MS HELEN
Spokesperson, Bunbury Birth Choices,
PO Box 299,
Capel 6271, examined:

The CHAIRMAN: On behalf of the committee, I welcome you to the meeting. You will have each signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record and please be aware of the microphone. Try to talk into it if you can. It is for recording purposes only. Ensure that you do not cover the microphone or make too much noise near it and please try to speak in turn. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of your evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. I reiterate that we have an hour from now. I do not know whether you want to include in your preliminary discussions some work on the computer. If you do, remember we have an hour for all that plus questioning. Would you like to make an opening statement to the committee?

Mrs Mansfield: On behalf of the community groups Birth Choices and Mothers Helping Mothers, thank you for the opportunity to present to the committee hearing. I am the spokesperson for the Busselton Birth Choices group. With me today is Helen Tarbotton, the spokesperson for the Bunbury Birth Choices group, and Kara-Jane Bennett, the spokesperson for the Mothers Helping Mothers group in Margaret River. I will discuss the perceived limitations of the available maternity care options in the south west, the importance and advantages of introducing government-funded midwifery-led care options for our community and the implication for not only these women but also the community as a whole. Helen, on behalf of the Bunbury group, will offer the committee some background about why we need a group such as Birth Choices, and provide some insight into

why women attend these meetings. Helen will also outline some of Birth Choices' recent concerns and achievements and give some personal experiences that have been kindly offered by some of our group's participants.

To conclude, Kara-Jane will give a local perspective on the Margaret River birthing community and its specific issues and concerns with the current available maternity care system. Kara-Jane is an active member of the group Mothers Helping Mothers, which has a similar philosophy to Birth Choices. She will also present to the committee a document of compiled letters of need. We have a copy for each member. This document is a collection of around 80 letters from mothers, fathers, midwives, other maternity care practitioners and businesses offering their thoughts on the need for a midwifery-led maternity care service in the south west region; that is, the need for a family birth centre and a community-based midwifery program for women choosing a home or hospital birth with a known midwife. These letters were collected through a community consultation process on current birth experiences within a limited publicly funded health system with regard to maternity health services. They were used in a qualitative study through a rapid analysis process. Each letter has been specifically written for your consideration as part of your public inquiry. These in-depth case studies also provide insight into the social phenomenon surrounding the birth experiences in the south west. What is presented to the committee today is an evidence-based interpretation. It was a real privilege to see the number of people who felt strongly enough to write us a letter in the past two weeks. Kara-Jane will expand more on the recurring themes and comments in the letters.

I am a mother of a 22-month-old and I am also a midwife. My daughter Lucy was born at home with the care of my two midwives and the support of my GP. I live in Busselton and work part-time as a registered midwife at Bunbury Regional Hospital. I also provide independent midwifery care for women who want to know their own midwife but also birth in a hospital. I provide backup to three community midwives in our community who provide a homebirth service. I back them up should they need a second midwife. This is in addition to the GP backup. I am involved in the Bunbury and Busselton Birth Choices groups. Through my involvement in these groups I regularly meet women in our community who are unsatisfied with the care they have received in the current system. They are very disappointed and quite surprised by the lack of options available to them once they fall pregnant.

Midwives are experts in the care of healthy low-risk pregnancy, labour and birth and the early parenting weeks. Midwifery requires specialist knowledge. By definition, midwives must be able to give the necessary supervision, care and advice to women during pregnancy, labour, birth and the post-partum period to conduct births under their own responsibility and to care for the newborn baby. This care includes preventive measures, the detection of abnormal conditions in the mother and baby, obtaining appropriate medical assistance in the occurrence of care deviating from the norm and the execution of emergency measures in the absence of medical assistance. A midwife also has a very important role in education and counselling of not only the woman but also the family and community. Their philosophy of care focuses on empowering families to trust in themselves and overcome any fears and uncertainty they may have of pregnancy and birth. Midwives care for women in labour and birth. They spend time with the woman, building a relationship of trust, understanding and respect. In my experience as a midwife and that of my colleagues, continuity of care by a midwife has been shown to have the following benefits: it increases mothers' levels of satisfaction in care no matter what the outcome; it reduces the rates of non-essential medical intervention such as induction of labour, instrumental deliveries and episiotomies; it reduces the request for pharmaceutical pain relief in labour; it reduces the overall length of labour, especially in first-time mothers; and increases breastfeeding success and long-term breastfeeding rates. These benefits are clearly identified within the national maternity action plan that was released in 2002 by the Maternity Coalition. This document is a blueprint for reform of Australia's maternity services. It was put together by pregnant women and mothers who are committed to seeing women have a choice of a known midwife throughout pregnancy, birth and a

few weeks after birth. It is based on scientific evidence that shows women and babies have very good outcomes from midwife-led care. It explains why reform of our maternity services is needed and how women and babies will benefit and it calls on our government to respond as a matter of priority.

Currently pregnant women in the south west have only two choices when it comes to birthing and pregnancy: all antenatal care is provided by either a GP or a specialist obstetrician and they birth in hospital with an unknown midwife; or, in the major centres such as Bunbury, they have the choice of shared care between the GP, obstetrician and hospital midwives clinic, which is run one day a week in Bunbury. These women birth in hospital with a midwife they may or may not have met previously. When a woman arrives in labour, it is usually the first time she has met the midwife who will care for her. Assuming that she arrives at the start of the midwife's shift, she has a maximum of eight hours to get to know this midwife, trust her and feel comfortable with her before the shift changes and she has to start all over again. It is a vulnerable time for women. This often happens more than once in the course of a normal labour. There is no provision in the south west for women who want to birth anywhere other than a hospital. There is no birth centre or community midwifery program for team or case loading models. Healthy, low-risk pregnant women should not be forced to give birth in a hospital if that is not where they want to be. I will refer to my PowerPoint presentation.

Ms Bennett: I have another document. It contains a copy of all our presentations.

The CHAIRMAN: We have a copy of that.

Ms Bennett: We are up to the third page of the PowerPoint slides.

Mrs Mansfield: I am sure members are aware of the intervention rates in Western Australia, but I want to highlight that in 2004 intervention rates were at an all-time high in Western Australia. In particular, Western Australia has the highest caesarean rate of all the states and territories, at 32.4 per cent. Just over 25 000 babies were born in 2004, but only 50 per cent of those women went into labour spontaneously. Of that 50 per cent, nearly half were augmented with an artificial rupture of membranes or an intravenous drip, and only 13 per cent actually went on to have an unassisted vaginal birth. In 2004, 20 per cent of women did not have any drugs in labour. The epidural rate was 36 per cent, and 40 per cent of women had continuous monitoring in labour, despite there being no evidence that it is of any benefit. The percentage of women who gave birth in hospital was 99.1. For your information, I also have statistics on Bunbury Regional Hospital. Last year we had 771 babies, or 761 pregnancies allowing for twins. Our caesarean rate, including both elective and non-elective, was 31.5 per cent, and normal vaginal birth was 58.6 per cent, which leaves instrumental births, such as vacuum and forceps, at 9.7 per cent. Induction of labour is 27.2 per cent, and epidural rates for those women having vaginal births is 26.34 per cent, not including caesarean epidurals. On a positive note, 90.6 per cent of all vaginal births were done by midwives.

It is estimated that the cost of vaginal births in the public hospital system, depending on the level of complications, ranges from $2 435 in the best case scenario to $3 790. A straightforward caesarean birth would cost between $4 420 to $6 870 for the more complicated cases. This includes labour, birth and the average-length hospital stay after the birth, but does not include any antenatal care. Compare this with the community midwifery program in Perth, which has been running for 10 years. The total cost for a normal birth is approximately $2 300, and this includes not only labour, birth and the postnatal period for up to six weeks, but also all antenatal care. Even the best-case scenario in a hospital is still more expensive than a community midwifery-led birth.

We have provided each of you with a copy of a midwifery care program submission. This proposal is with the Department of Health of WA and the WA Country Health Service. This document was prepared by the community consumer group Birth Choices in partnership with local independent midwives and consumers and was submitted at the end of September this year. The conceptual

development of this program has been in the making for at least five years. In the coming weeks, Birth Choices will also submit a similar-sized proposal for a south west birth centre through the same channels. The main reason for proposing these two models is to give south west families access to continuity of care by a known midwife. A local midwife, Pete Malavisi, has been caring for families in our community largely on his own for the past seven years. He has provided women with the choice of homebirth with the support of local GPs. He has also been invaluable in his support of independent midwifery-led care and his contribution is enormous. His experience and vision have led to the development of both this women's midwifery care program and the south west birthing centre submission that will be following in the next couple of weeks. These submissions have been prepared in response to increasing local consumer demand for government-funded midwifery-led care options. The women's midwifery care program is a detailed submission asking the government and the Department of Health to allocate funding for a community midwifery service. Women in this community are very disappointed with the lack of options for maternity care, as you will see when you read the letters-of-need document.

The proposed community midwifery program will enable women to choose a midwife as their lead carer throughout pregnancy, birth and the early postnatal period. The midwife will work collaboratively with the woman's doctor to provide the necessary physical, emotional and spiritual care and support that the woman needs at this time. The majority of care will be conducted in her home, where she feels most comfortable. It is envisaged that the women who will take advantage of the midwifery care program may choose to give birth either in a hospital or at home, and hopefully in the future we will have the choice of a birth centre. The continuity of care and subsequent trust and rapport are the most valued aspects of such a model.

Women who do not wish to birth at home or in hospital should have the option of a birth centre. Our future south west birth centre should be a freestanding building adjacent to a hospital campus. It should contain two birthing rooms each with a private ensuite and bath. In the south west birth centre submission, we are proposing a Vasse location, although we wish to emphasise that if a Bunbury Regional Hospital location was seen to be more appropriate, that would be fine. Run by a team of midwives, it should provide one-to-one care and the birth centre midwives should provide antenatal, birthing and postnatal care for up to six weeks. The midwives should also provide education clinics and workshops and be on 24-hour call and have the support of local GPs. Birth Choices' birth centre proposal mentioned the future Vasse site, mainly due to its centralised location between Bunbury, Busselton and Augusta-Margaret River, which is essential for travelling times. A completely new health precinct will be constructed there in the next five years. Two GPs in Busselton are already actively promoting a birthing centre and have secured land free of charge from the developers for the purposes of a birth centre, if we were to get one. Ideally, we would like to see more than one family birth centre in our region. I will mention the future directions in maternity care document released by the Department of Health last month. It repeatedly states that women who are unlikely to experience complications during pregnancy or labour should be encouraged to use locally based midwifery care programs and practices and have greater access to homebirth and birth centre options. We have read the document and support those recommendations.

Based on anecdotal evidence, approximately 30 women a year in the south west employ their own midwife, either for a homebirth or hospital birth. The midwife will do shared care with a doctor, who is usually a GP. I can assure members that the number of calls we receive as independent midwives is easily more than double this number, but unfortunately the cost is prohibitive to most of these families. Even though women are able to birth in a public hospital with no cost incurred to them, some still choose to employ a midwife to care for them during pregnancy and to go to hospital with them for the birth. They usually choose to birth in a public hospital due to its lower rates of intervention compared with the private sector. They employ their own midwife to further improve their chances of going through the birth process with as little intervention as possible. The

fact that women are prepared to pay for their own midwife in the current hospital system proves how important it is for them. The midwife provides an average of six to 10 antenatal visits, with each visit usually in excess of one hour. The midwife is on 24-hour call for her clients for between 37 and 42 weeks over the potential birthing period. Once labour starts, the midwife attends the woman's home and continues to care for the woman until she births. A second midwife is organised as backup should she be required. There are always two midwives present for a homebirth as it is safe practice. The same midwife also continues caring for them at home for the immediate postnatal period, with daily visits at least for the first six days, and is available for 24 hours by phone. This midwife remains involved with the family for six weeks postnatally, at which stage the mother is referred back to her GP and the local child health nurse for ongoing care.

Such is the importance of having this option of a known midwife in our community that women are currently investing a substantial amount of money out of their own pockets to employ their own midwives. Many of these women use their maternity allowance for this purpose. Obviously, this is inequitable. In the past two years the number of independent midwives in the south west has grown from one to eight, although one has recently moved to Sydney. The demand for their services is proof that midwifery-led care is highly regarded in our community. Presently, all seven are self-funded and must provide their own equipment and resources, and pay for their own travel expenses. A government-funded midwifery service in the south west region of Western Australia will have benefits for not only the women and families that they care for, but also the midwifery profession, the Department of Health, the community, the WA Country Health Service and the government. It will provide more choices for pregnant women and their families; help take birth back to the local community areas; provide greater levels of satisfaction; help minimise the impact and occurrence of postnatal depression; have a greater family focus; help retain midwives in the profession due to greater satisfaction levels; free up GPs' time; allow for a greater amount of time spent with the pregnant woman and her family and therefore a more thorough assessment; improve working relationships between doctors and midwives; provide cost savings to the health service due to reduced intervention rates, fewer caesarean sections and hospital services; and provide greater breastfeeding success. By funding programs such as these two, the known benefits of midwifery-led care would become equitable, accessible and affordable to all women who would like to choose this option, not only those who can currently afford it. Women of the south west would like to take responsibility for their care and they want continuity, choice and control over what happens to them. On behalf of these women and their families, we will continue to lobby for midwifery-led care in our community. It is totally unacceptable that women should be denied the right to a government-funded homebirth or a birth centre when women in Perth have been receiving this service for 10 years. Thank you very much.

Ms Tarbotton: I will put on the PowerPoint presentation on at the same time to speed up the hearing to avoid going over time. This is an emotional topic so members will have to bear with us. I am also pregnant, so I might cry.

I am Helen Tarbotton, spokesperson for the Bunbury Birth Choices group. I am here today to let committee members know what goes on in our meetings and what the ladies have asked for during those meetings. We restarted this group two years ago in October 2004. Our meetings are run on consumer need. We have monthly meetings. Pregnant women attend our meetings, as well as midwives from Bunbury Regional Hospital. We try to bring the two together to build a relationship and rapport. The families come along to basically meet the midwives and build a relationship with them, as well as attending the clinics with the midwives, to have a relationship prior to the birth of their children. The PowerPoint photos are rather dark, which is a shame. Guest speakers come along to the meetings to volunteer their expertise. Midwives speak on various topics on birthing, usually in a hospital setting but also per se. Topics include the induction rate and what it is to be induced and the ramifications of that for a woman's birthing experience. For those who are unsure what VBAC is, it is vaginal birth after a previous caesarean birth. We have people speak on that,

including mothers who have achieved vaginal births after caesarean births. We have talks about hormones during birth, the types of hormones and how they allow a natural birth to progress. Some will impede the birth if the fright and flight kicks in during a birthing experience. We have talks on the use of water for management of pain relief and helping to achieve a natural birth. We have talks about some policy changes within our hospital in particular, because mothers are asking about it; for instance, strip B testing and its ramifications, why it is necessary, what is it and so on, and vitamin K injections, to mention just a few. We have also had many speakers from alternative health therapies come in and help the ladies learn about homeopathy, reflexology, hypnobirthing, osteopathy, bush-flower essence therapy, massage therapy, yoga and also Buteyko breathing method.

I will briefly go through our points. They are not all our concerns, but I have tried to bring together the main concerns that recur throughout our meetings. The ladies come to us when they are about three months pregnant and leave about six weeks after they have given birth once the breast feeding is up and running. We often do not see them again although some continue to come after they have had their child. During pregnancy and after birth they often raise these concerns. Sam has outlined these in her talk, so I will not go into a great deal of depth. These ladies are saying that time management, which Sam mentioned, is interfering with their ability to birth in their own natural, physical and hormonal manner. For instance, they are given a set amount of time in the first stage of labour to dilate. During the second stage they are given only a certain amount of time to push. During the third stage an injection is often given to birth the placenta, as members may or may not be aware. Many women mention that once a woman has been induced, there is a cascade of medical intervention that she did not want or hope for during the birthing experience. Women find that they often receive intrusive vaginal examinations on change of shifts, epidurals that affect their birthing experiences and, eventually down the track, vacuum forceps and caesarean births, as a result of the cascade of intervention during the birthing experience.

They talk about the lack of continuous care; the fact that with the changing of shifts, as we have mentioned, a new GP or obstetrician will come on board. Those people have their own set parameters and ideas of how birthing experiences should unravel. Women say that often because of a lack of rapport, their birthing plans are disrespected or not read. They have to fight the fight in the middle of a birthing experience, rather than someone respecting what they are asking for. Husbands come along and also talk about these issues. Families come to our meetings from as far as Balingup, Bridgetown, Waroona, Brunswick, Harvey and Donnybrook. They are all saying the same thing: it costs them a lot of money when birthing in Bunbury. They often have to leave their families. The fathers must stay behind and look after the kids or, if the fathers join the mothers, they are not allowed to stay overnight in the hospital. I know several fathers who plant themselves in a chair and not move, but it is not hospital policy and hospitals do not provide for it. The fathers are frustrated by that and the women feel unsupported. It is expensive for them because they must travel a great deal to Bunbury for checkups. They are not getting monetary support from the government for this, which is unfair.

If they want to use alternative therapies, such as aroma therapy, acupuncture, homeopathy or anything of that nature, it must be documented prior to their birth experience by a GP or obstetrician currently in the hospital. Many of them say they are not made aware of this until they are in the birthing experience when they are told that they cannot use it because that is the policy, which catches them off guard. They have planned for one experience and, all of a sudden, they are put into a different experience.

The subject of water birthing is raised a lot in our meetings. Some women feel comfortable in a bath, but they are not allowed to remain in the bath. They must be removed from the bath or the plug is pulled prior to the birth of their child. It is safe practice internationally and even nationally. In Sydney and New Zealand it is common practice. Why is it not allowed here? That is the question they ask. All these matters have an affect on their ability to breastfeed with confidence

and ease. Breastfeeding is incredibly important for their development and the development their children.

These are photos of our lovely midwives who work independently and are helping to achieve supported births in a hospital setting as well as in homes. Members will see many of their faces here today. These ladies are saying it would be great if this could happen, please. I am passing on their messages, which are written in the letters in the booklet. They are asking for alternative birth environments. They want to know why they cannot have a regional birth centre. I know I have said that travel is an issue, but they do not mind travelling to a birthing centre if it means that they can have their family with them and their husband can stay on with them, which is the whole premise of a birthing centre. It is a more family oriented environment. People from small country towns are asking why their maternity wards have closed down and why are they not opened up again for no-risk women and attended to by midwifery-led care. That is set out in that document. It has been suggested it is cost effective. I believe it is happening in Denmark down south. Why can we not do the same for Pemberton, Bridgetown and Donnybrook?

Why can we not have subsidised government funding for homebirths down south or for employing a midwife in a hospital? It is happening in Perth, where, we believe, there are 150 funded positions. People are allowed to access it in Mandurah. Why are we not allowed to have it here?

Women want better relationships with their midwives. They want case loading. They want to employ one midwife for the beginning, for their birth experience and to help them at the end with their needs for breastfeeding. Conversely, why can we not have team midwifery within our hospital system; four midwives being assigned families, so that the women know at least one of the four or, if two come on and off shift, the women will know their faces as they walk in the door. It happens in other hospitals. We know it happens in Sydney, because one of our midwives is over there. She cannot believe we are not applying the same policies. If all that was happening, one of their very big wishes is to have less medical intervention. They want to look at revising induction rate time frames and parameters, the use of drugs and so on. They ask that they can have their birth plans respected. Those are their words as well as other people's. That is why I am bringing them to your attention.

Before I close, I will quickly flick through these photos. This photo is from a recent meeting. Tamara is trained to be a Doula. She has no medical training, but she now supports other women in birthing. She cannot give any medical advice, but she will go to hospital with a mother and help to achieve a natural birth if that is what a woman wants. She will support whatever type of birth the woman would like. Jody employed Angela Jordan and Susan Krachler at home and hospital births at her own expense. It has cost $2 500 or $3 000 of their own money for those women to employ midwives. Clair Bedford recently gave birth to Izaak. From her own money again she paid for attending midwives Angela and Susan. She has given me permission to say this: she is a so-called high risk lady because she has been diagnosed with epilepsy. She has support from Dr Keith Howe. He monitored her and went through her statistics and so on. He supported the birth. The midwives recently helped achieve a home water birth for Clair with Izaak. This picture show Ellie is cutting the cord of baby Izaak's brother. This is just to bring it home to you. It is very special for them. It is spiritual as well as every other aspect. Ellie was born by caesarean section. Hazel came to Birth Choices. She was under supported. She wanted to have a caesarean section for personal and very real medical reasons. Dr Keith Howe helped her. He revised her details and helped support her to have a lovely caesarean section. She had aroma therapy, music and skin on skin as soon as Ellie was born, which gave her attachment as soon as possible. It was a successful caesarean birth.

This pictures shows the birth of my son at home. It was a water birth, which was again personally funded. Julie Stockwell, who is now in Sydney, is my sister-in-law but she was supported with Pete Malavisi at home. This will make you cry. This is Sam giving birth at home. Julie is in attendance. Pete again support it. It was a privately funded homebirth. Without too many details, I

can say that Sam's birth would have ended up with a caesarean section in a hospital setting, we believe, because of the time management issues that we have been talking about with the dilation and pushing stage. Every lady has individual issues in birthing. This picture shows Lucy at home with husband Simon. This one shows cutting the cord. Charlotte came to us. She achieved a beautiful natural birth in a hospital setting. She had a fantastic time in hospital with the midwives. She came to our meetings and knew most of those present. Fortunately, they were on shift. She had a great experience. She is currently employing Susan and Angie to have a second child at home, almost to the day. She is due right now. The first time she wanted a homebirth she could not afford it. The photos are of Kerry, Nigel, Sacha and Charlie. It was a water birth with Pete Malavisi, again at their own expenses. They adored the experience their own so much they did the same with the second child. The face of Nigel is incredible in this photo. This photo is of Kerry with baby Charlie recently. Again they had Pet Malvisi at their own expense, which was $5 000 to $6 000. This is a photo of Jess and Tavia. Jess gave me permission to use this photo, and I hope you are okay with it. Tavia is in the water with mum and Julie is supporting her. She was a high risk mum. She got feedback at an early age. Her second birth was a homebirth water birth, again at her own expense. This is the beautiful Jess recently giving birth to Shuanti at home. This is her third child by a homebirth water birth. The is a very intimate moment soon after Shaunti's birth. These photos of the Sydney birthing centre. We are trying to highlight that there is a need for it to be a lot more relaxing and less medical. Women are after this type of thing.

This is a quick run down of the articles we have put into the media to get support. This was a very important article. Sam's Busselton group has, after five years of lobbying and fundraising, obtained a second bathroom attached to the birthing suite a Busselton hospital, so that was a success story. This article was running support for the birthing centre. Charlotte was asked to leave 20 minutes after the birth of her first child, to be shifted off to a ward because Bunbury Regional Hospital was so overcrowded. Overcrowding is a huge problem at Bunbury Regional Hosptial. Julie supports alternative choices in the south west. The numbers have cut off by the scanning, but we raised 1 253 signatures, gaining support for a birthing centre in the south west. We submitted that to Adele Farina.

I thank you for listening to me. I hope that my talk has helped in some way to allow the families I am speaking on behalf of greater choices in birthing experiences and midwifery-led care, and so that the midwives of our area can regain their status as experts in natural birthing. Thank you.

Ms Bennett: I am Kara-Jane from Mothers Helping Mothers in Margs. We have been going for a year and a half or less. We came out of Margaret River Birth Choices but it changed over. The women there felt unsupported so we thought we would come together and do advocacy work, education, awareness raising and support work. We have a support group on Mondays for a couple of hours where women can connect with other women about birthing experiences, pregnancies or early days of parenting. We also felt that there was a lot of fear of the antenatal processes in preparation classes in hospitals. We decided to develop our active birth workshops with the emphasis on empowering the mother to believe her body is capable of doing it itself and empowering fathers to become active birth parents and partners. The success from active birth workshop has been great. We have had four. Most of the girls have ended up with the birth of their choice. In most cases the girls have said no to intervention and have pushed to have a natural birth. Like Bunbury Birth Choices we wanted health seminars. We wanted to upgrade our skills as carers for ourselves and children so we had alternative practitioners and GPs come and talk to us. We recently ran a local birth forum to which we invited consumers, midwives, GPs, and alternative practitioners to come together and brain storm about Birth Choices in the south west and try to integrate more and become a holistic system.

All our activities have been run with the assistance of local midwives. We are effectively a midwifery-led program without the formal capacity of midwives and the program. We are responding to a need. I have done community development and community action for a long time.

For me it was an amazing phenomenon to collect 80 letters in two weeks. The women are saying they want change. The group of people who supplied letters have generally either had an unsatisfactory experience in a hospital or know that there are other Birth Choices that they could use. I implore members to read through the letters. The feelings are amazing. I feel so privileged to be able to read them and understand where these people are coming from. They are very intimate moments in people's lives and are very sensitive. There are 80 letters from people from Bunbury to Augusta. They are generally painting a picture of experiences of birth in the south west. Both mothers and fathers willingly and easily gave of their stories. They state clearly why and how they need the change. Many diverse birth experiences were discussed in the letters: hospital, natural, intervened, caesar births, at home, water births, in birth centres and other maternity care programs in other areas. Across this diversity there were many common issues about the current limited publicly funded Birth Choices.

This is what they are saying. It came down to six themes: midwifery support, parent development, about our choices, nature of the current practices, the growing need, and knowing women for support. Under the midwifery support theme, midwifery support is seen as a specialist knowledge that is safe and nurturing and in many cases unconditional and easy to access. It was also seen as providing continuity of care. Many fathers expressed that they were much more involved in preparations for birthing in the midwifery-led care program and they very much enjoyed that. Under the parent development theme, those who experienced a midwifery-led care birth preparation found the education awareness raising the midwife provided to be invaluable in creating the birth outcome they wanted. Many expressed enjoyment and appreciated the emotional and spiritual development the midwives offered.

The next theme is about our choices. Many expressed the inequity issues of city-based mothers and mothers in other states having more choices than regional WA mothers. Many who used a midwifery-led care process for their birth felt frustrated that they had to fund the cost at a time when they needed it most, knowing that in other areas it is levied through Medicare. Nature of current practice: pregnancy was not seen as an illness and being cared for through doctors' surgeries and hospitals felt wrong. Many felt they were filling up unnecessary spaces in these places. Many felt hospitals have a culture of fear, risk and intimidation. They felt unheard and disempowered, with a lot of unnecessary involvement. The current doctor/hospital birth choice was often seen as impersonal. Mothers felt managed according to time outcomes and risk trends. There is more. The growing need: many of the mothers stated they wanted their own midwife but found it hard as there were few to access and they were too costly. As midwives were involved from early pregnancy, a relationship of rapport, intimacy and trust had developed. This was seen as very beneficial to the birthing parents. They want individualised care.

The last theme: a known woman for support. Many of the mothers talk about the benefits of having a mothercare assistant, otherwise known as a doula, present. In antenatal preparation, the mother found comfort in the listening and counselling skills of a doula. During birth the mothers expressed a great trust and appreciation with doula caring for them while birthing. The doula focused particularly on the mother. After birth, doulas were considered critical when adjusting to life with a new baby. They were forever on call.

I will go through a handful of case studies from the letters. Karen's story is that she had a normal hospital birth. She has two children. She birthed her first child in Belgium in a birthing centre and a second child in Margaret River Hospital. Both were considered to be normal pregnancies and birth. She very much enjoyed her first birth experience but felt her second led to postnatal depression. With her second birth the hospital staff were not aware of her birth desires. In many instances she felt she was intervened on unnecessarily or without permission. She felt there was an overall hurried approach to her birth. She was not listened to and became very tired. It was discovered when her waters broke that meconium was evident in the sac. From this point on,

decisions were made on her behalf and it was very disempowering. Karen was diagnosed with postnatal depression and four years later is still trying to overcome some of its manifestations.

This is Muriel's story. She has two children. It is a similar story to Karen. Her first child was born in a holistic centre in Switzerland and the second child at home with a water birth. English is her second language and she moved to Australia at the time of her second child. She was very anxious and frustrated with the poor selection of birth choices in Margaret River. She found a midwife to assist her in homebirth and preparation. She found her midwife listened and allowed her to ask questions during antenatal visits. Her midwife informed her of all the options, which allowed her to make the right choices for her family. She encouraged her to believe in the natural birthing processes. The homebirth was very inclusive of her partner and she was able to move around freely as needed. She had an early baby and found her midwife to be so accessible and available for postnatal care. The midwife became the third most important person in that child's life from the beginning.

Angie's story: Angie has had two homebirths and has a third baby on the way. She intuitively knew she wanted a homebirth. She, like most of the other girls, felt frustrated with the inaccessibility and lack of independent midwives in the Margaret River region. She found the antenatal visits in the home invaluable as all fears and possibilities were openly discussed. The midwife became an extension of the family. She had a great empowering experience with great bonding and breastfeeding. Angie believes her births were ecstasy. They are still very close to their midwife four years later. They funded this type of birth through a repayment process with their midwife. They are going into their next year of life handing out payments. How does a midwife make a profitable business out of that experience? She found it inequitable having a birth that cost the medical system very little and then having to pay for it themselves.

Maria's story. Maria researched a range of birth choices to go through. She decided to choose an independent midwife as it offered continuity of care during pregnancy, birthing and early parenting days. She wanted someone to be with them if an emergency eventuated and who could help them make decisions at that time. They used their entire maternity bonus to pay for it. She felt penalised for choosing midwifery-led care and frustrated with the inequity surrounding choice. Would like to see a holistic birthing support centre housing midwifery-led care.

Lynne's story. She has two children. Both were born in hospital by caesarean section. The first birth was spontaneous labour at 35 weeks. She found the process to be disempowering and the decision making taken away from her, especially as she is a trained midwife. Lynne has been suffering postnatal depression since the conception of her second child. We know these people. She is very concerned about the effects of depressed mothers on the early stages of a child's life. Lynne's second birth began at home and later she had to go to hospital. She and her midwives worked hard to allow her birth wishes to eventuate and when they altered she was involved in every stage of decision making. Lynne found her birth process to be self-fulfilling in many aspects and is not suffering from postnatal depression with her second child.

Jolene's story is amazing. I will cry with this one. The initial birthing experience was traumatic. Julie has three children, two by caesarean section and she got to a vaginal birth the third time. They were all normal pregnancies. Her first experience was at the age of 22. Jolene's story is a classic case of young people not being guided and supported in the medical system. Her labour began at home when she rang the hospital and they told her to come in. She went into the Margaret River hospital and meconium was present in her waters and she was sent to Bunbury Hospital strapped into an ambulance bed shared with a footballer who had a broken leg. She told me all she remembers was the smell of the footballer while she was having contractions. When she got to Bunbury hospital, she had another internal examination and she was advised it would be best it she had her baby within two hours to reduce the potential of infection on her child and then she was advised to have an epidural and oxysyntocinon to begin the labour processes - an epidural in case it

turned into a caesar. She had a foetal monitor and had a cannula on her wrist. Effectively, she was strapped in at four different places, which made it very difficult for her to move. When she was eight centimetres dilated the midwife asked her to get on all fours. She looked and found the baby was caught on the lip. At that time the doctor walked in and said, “What are you doing?” and asked her to move back onto her back. She retreated into three centimetres dilation. After that point it was a caesar. She had caesar processes and then she was moved to recovery and then into her ward where she was left for some time until a nurse came round to see how she was getting on. At that point she realised that no-one had attended her and her bleeding had saturated the bed. The nurse went to take the sheets off and she could not move her because she was too heavy. The nurse went to get help. She put the sheets underneath her bottom and left her fully exposed. Jolene had not been washed or cleaned after her birth experience and was totally exposed to visitors walking through to the other mother. Two males walked through and saw her totally exposed and she was left there just raw. After that point she requested to go to Margaret River hospital. Consequently, Jolene developed severe postnatal depression and her marriage was challenged.

She wanted to have a homebirth for her second birth. She could not find a midwife whom she felt comfortable with so she went through the GP. When it came time for birthing, Jolene wanted that particular GP and the GP told her the only way to do that was to pay her through private health insurance. She was then told she was going to have a student obstetrician GP manage her birth. In the birth the baby slipped back into the womb and swallowed water. Her baby was in an emergency care unit for 36 hours. Consequently, her post-natal depression was more severe and she was managed with drugs.

Jolene fell pregnant again with her third child and became a member of Mothers Helping Mothers in Margaret River. She came each week and sat with us. She asked questions and we supported her and networked with her to help her find a general practitioner who would do a vaginal birth in a hospital. Dr Keith Howe came to help in the twelfth hour. Jolene had a successful vaginal birth. Jolene worked hard to re-empower herself with knowledge, support and encouragement from the mothers’ group.

Our vision for Margaret River and what we wish for is a holistic and integrated family support centre - we are more regional than Busselton and Bunbury - with a midwifery-care program. We want a drop-in service for mothers and bubs operating from Monday to Friday with counselling, education and awareness-raising activities for conception, pregnancy and parenting from zero to five years of age. We want a formal Doula system administered from the centre. We would also like to link it into research to show that support through antenatal preparation has better birthing outcomes. What we have currently is a location, collaboration with CWA in Margaret River and a growing number of independent midwives. We currently have three businesses with six independent midwives. We have growing awareness in midwifery-led care and an historical phenomenon with homebirths being normal in Margaret River. We have established educative and awareness-raising activities. We have a collection of people who believe in a centre like this is needed in Margaret River. We are very skilled. We also have liaison and networking with the Fremantle midwifery-led care program. Finally, we also have a large collection of women already acting as Doulas.

I will now provide some parting thoughts. Children are born into families, communities and societies. As such, maternity care must be back in communities and homes. The hospital maternity carer is the supportive model, particularly when normal pregnancy and birthing becomes abnormal. Mothers and fathers are saying that they felt more secure and supportive when a midwife was present from conception, birth and the early parenting months. A government-funded midwifery-led program would deliver this. There is limited choice available. A broad range of choices more suited to the need might avoid some of the traumas and interventions that are occurring. A mother told me that it is time to listen to the women and their families to reduce the untold social and psychological costs that are brewing. Thank you very much.

The CHAIRMAN: Thank you very much. It has been difficult to listen to your evidence. We will follow up with some questions. You have given us a good outcome of Birth Choices and the groups that you represent. You held up a booklet about the future directions in midwifery. There was a consultation session with that. I assume that you will have some input into that. I want to know whether you were consulted or whether you had any input in the discussion process that took place around the Cohen report, the Reid report or the clinical services plan that was undertaken by the health system over the past five years.

Ms Tarbotton: No. Birth Choices has not been consulted. That is the short answer.

Hon SALLY TALBOT: Are you affiliated to the Maternity Coalition?

Mrs Mansfield: Yes. In essence. They made submissions.

Mrs Mansfield: We were not contacted personally as a group to have input into any of those inquiries or the development of this document. We support what the Maternity Coalition stands for and its views and recommendations. As a group Birth Choices was not consulted.

Ms Bennett: We networked among ourselves when the discussion paper came out. We had an e-mail asking about it. That was two weeks ago before we got an invitation to this committee. It is via a web site. It is a 54-page document. For a mother, I have a background but for a mother 54 pages is inaccessible. We intend to provide comment on it. Until that point there has been no formal involvement.

Hon SALLY TALBOT: Do you feel that you have fed some of your ideas to the Maternity Coalition?

Mrs Mansfield: In my involvement in the past five years, I have not had any involvement with that group.

The CHAIRMAN: The consultation phase for consumers and users of the future maternity services is a seven-week period from whenever it started - I think it was October - through to Christmas. Can you comment on how you see that being a way of finding out what mothers want?

Ms Tarbotton: I am the mother of one and I am about to give birth to my second. I have to log in, unravel the document, write a submission and forward it by e-mail. I try to give it time. I do not think that the process is adequate for someone who is busy and trying to do their best as a mother.

Ms Bennett: When I found out about it, I e-mailed the future directions group and said that I would run some consultation workshops down here if it funded room hire and baby sitting. We cannot listen unless our children are cared for. I received an e-mail saying that there is a two-phased process and that this is going out to key stakeholders and that it is a discussion paper format. It is a formal process of submission. There will be a second wave from January to March next year. I have issues about that because of holiday time with family and accessibility. That is the nature of government and community differences. I was told that we would be involved in policy development at that stage. That is how it was explained to me. I e-mailed back and asked what is considered a key stakeholder. I have not heard anything as yet. I am advocating for it.

Hon SALLY TALBOT: I refer to the final dot point. You obviously do a lot of networking within the region. Are you aware of any stakeholder group in this region that does not support the sorts of things you are talking about and the two models that you have under consideration?

Ms Bennett: I went out to some playgroups because I wanted to get outside our circle of thinking. I talked to two groups - one at Rosabrook and one at Augusta. I found the experience quite interesting because the girls consider it normal. When I talked about choice and encouraged natural birthing processes as another way of approaching birth, I saw lights turn on. Girls just run along with that process because that is all they know; they do not need to question it because that is how it has been done. When I talked about these things, some of the girls, particularly the caesarean girls, said that they could have avoided that. To me that was an interesting thing.

Hon SALLY TALBOT: I will ask the question the other way around. Are you meeting any brick walls?

Mrs Mansfield: We have not received any feedback at all on our proposal. It was lodged in September and we have not received any feedback at all.

Hon SALLY TALBOT: So local GPs, obstetricians -

Ms Tarbotton: The other side of the coin is covered quite well. Our frustration is trying to get these points of view across as though they are not abnormal or that this is not an unusual view. I do not want to state names or to strip a certain professional or academic style of thought, but there is enough support for the medical model and for medical intervention in the birthing experience. We are trying to say that there is another side. Can we look at that other side and support women who want an alternative model of care? They want to achieve natural births. They want the empowerment of it. It is very real and it needs to be listened to. Our hospitals are getting tighter and tighter with their policies. They are restricting the way women and families are birthing. Our viewpoint is that that is covered well and truly. The alternative is not.

Ms Bennett: I have approached GPs on numerous occasions to become involved with mothers helping mothers and health seminars. We had a birth forum six weeks ago and we invited every GP in town, particularly the obstetrician GPs. No-one was available. It is hard to even talk to them or to get access time. It was suggested to me that I make an appointment with one of the doctors, explain my case and then fill out a Medicare form. I thought that was a little unfair and inaccessible. We are locked out of dialogue.

The CHAIRMAN: When an independent midwife goes with a mother to hospital, because it has been changed from a homebirth to a hospital birth, can the independent midwife continue to provide birthing assistance to the mother? If so, what is the status of the midwife as the birth takes place in the hospital?

Mrs Mansfield: Until recently, as independent midwives, we would officially be supporting people. We would not have an official role or be able to do any documentation. Three or four weeks ago that changed. The midwifery unit manager has talked to the hospital administration, and it is happy to employ independent midwives as casual midwives. We are all employees of the hospital already. When we come through the door with the women, we are employed as casuals. It is great. It is a huge step forward. That is in Bunbury. That is not a blanket arrangement across the south west, but it is an arrangement we have with Bunbury Regional Hospital. It defeated the whole purpose. I do only hospital cases. I am not willing to be a primary midwife in a homebirth situation, yet because there is no insurance available. When I walked through the door, even I felt disempowered because I knew what they wanted; and, depending on the hospital midwife who was on shift, I felt like I was in a battle. A great thing happened a few weeks ago. Now that that has been taken out of the equation, there is no stress involved.

I will go back to the doctors and obstetricians and getting the women's midwifery care proposal together. For the past couple of years we have been asking obstetricians in particular to talk to us and work this out between us. Basically, we keep getting knocked back. They do not have the time and keep fobbing us off. We wanted to talk to them before we produced and lodged this document so that everyone was happy, but we could not wait any longer and we just wrote it. We sent copies to them, the Department of Health and local stakeholders. We received a quick paragraph thanking us for having sent it and indicating that they had not had a chance to review it and would get back to us. They have it and will read it.

Hon SALLY TALBOT: Returning to the admission to hospitals, are you saying that that has changed in the past month?

Mrs Mansfield: Yes.

Hon SALLY TALBOT: However, is that only for Bunbury Regional Hospital?

Mrs Mansfield: Yes.

Hon SALLY TALBOT: It is not for Margaret River or Busselton.

Ms Tarbotton: Generally, most transfers would be because the birth had become a high risk.

Ms Bennett: In Margaret River there is obstetrician GP activity. That is why there has been a growth in independent midwife businesses because they can do the obstetric surgery at the hospital.

The CHAIRMAN: I am interested in birth plans. You have talked about a birth plan for a woman who has a baby in a hospital. Can the mother and father collectively, or the mother individually, identify and make clear their choice? Is it something they sign?

Mrs Mansfield: No. Usually, it is a one or two-page document that they might have typed up on the computer at home stating the main points that are important to them as a couple.

Ms Bennett: It is not obligatory.

Mrs Mansfield: Sometimes they are verbal. For example, a midwife knows exactly what the couple wants and the important points about the birth have been discussed throughout the pregnancy. However, for women who are booked into a hospital with people they do not know, they feel the need to write dot points on a one-page document; for example, they want such and such to occur, they do not want their babies taken away from them for routine measuring and weighing, and they want the first breastfeed to happen within an hour. Those are the types of really important things they would write down.

The CHAIRMAN: Is that information made known to the staff at the hospital?

Ms Bennett: It depends on whether the couple ask for it or whether they are assertive and give it to them; otherwise it is implicit.

Ms Tarbotton: Our group has put out four pro formas on the different styles of birth. A woman might want a vaginal birth after a caesarean. There are about four different types of birth plans that we have given to our ladies, and they are available to be downloaded. We have encouraged them to write it down and let as many people know prior to the birth that it exists and that that is what they want. Our group in Bunbury has been encouraging that for any style of birth.

Ms Bennett: When I wrote mine, it was confirmation for me, too. I was setting the benchmarks or goals, or whatever. When you are writing it, you are really making it apparent to yourself what you want, and then you give it over and it is transparent.

The CHAIRMAN: To look at it from another point of view, once it is given over, to do otherwise could be deemed to be assault. I do not suppose anybody has ever tested that. If it was not followed through entirely, it would be unusual for that not to be considered an inappropriate practice.

Ms Bennett: If people are asking me all the way along the process about what is happening, and it ends up being a highly interventionist traumatic birth, I would find that a good place to start.

Ms Tarbotton: Often women will write a birth plan through a GP or an obstetrician; however, they should not be set in their view that that is how it should happen. It often changes. Often they are disempowered even before the birth. Birth plans are all well and good, but women should not feel broken-hearted if they do not happen that way. It is almost as though the power is taken away from them before it is even allowed to happen.

Hon LOUISE PRATT: Assuming that there is a positive future for the kinds of models of care that you have put forward, what challenges do you see in transforming the local work force - GPs and midwives - to accept those models of care? I am noting, for example, that some of the people who opt for a homebirth currently might be deemed too high risk for a government-sponsored program or are not an acceptable travelling distance from the hospital, and those kinds of issues. Do you have any insights into how those issues could be dealt with better in the future?

Mrs Mansfield: From a professional point of view, it is already happening. However, it is just not government funded. There are more than enough midwives to staff a birth centre and a community program. There are GPs in Margaret River, Busselton and Bunbury - at least two in each town - who also support these women. The south west birthing centre plan is basically modelled on the King Edward birthing centre. We plan to practically adopt its policies. We will have to adjust a few things to suit our local demands, but it will have similar, if not identical, policies, procedures and guidelines. We adhere to the Australian College of Midwives guidelines. We are not out there to do anything dangerous. We just want extra choice for women. It is part of that. When we come to an agreement about how it will work, everyone will have to adhere to those policies.

Ms Tarbotton: Those women who may have to travel a bit further to get a sponsored homebirth surely will make arrangements for that. I know people in Balingup who have done that. One couple who wanted to have a home water birth came to Bunbury so that they would be closer to Bunbury Regional Hospital if necessary. I am sure that those families who are passionate about that style of birthing will still make it happen; they already are.

Hon SALLY TALBOT: The first dot point on the second page of your submission refers to the advantage of midwife-led care, and the second dot point refers to increased service or satisfaction no matter what the outcome. What does "no matter what the outcome" mean?

Mrs Mansfield: I am referring to something that went other than was planned. The birth might have ended up in a hospital when it was supposed to be a homebirth, or it might have ended up being a caesarean. Women find that no matter where they end up, if they have had support, involvement and decision making on the way through and they feel that they have been given every opportunity to achieve what they want to achieve, they can deal with the outcome, because they have had that continuous support. That is the case even in the worst-case scenario of a stillbirth or something like that. Women will feel supported and not as bitter as they would if that type of thing had happened in the hospital system and they did not feel they could go back and ask questions about why this had happened like that, or why that person had not done this or that. They have the constant midwifery backup of a person who was there with them and who can explain it to them and debrief them no matter what the outcome.

Ms Tarbotton: There are a couple of examples in Bunbury. One lady had employed a midwife for the second time round. She ended up having to go to hospital again for a caesarean. However, she was fine, because she was allowed to help make the decision, and she was informed and had support. There is another lady - I will not go into her story, because it is very sad, and she was hugely traumatised by it, so she is not ready to share it yet - who ended up having a caesarean section and who said that had she not had the midwives with her the whole way, she would have had postnatal depression. She feels okay now. She is breastfeeding, and her baby is going well. However, her husband was traumatised because of some of the things he saw. He is writing it down and sharing it loudly. She said it was wonderful that she had the midwives with her, otherwise she would be in all sorts of trouble depression-wise.

Hon SALLY TALBOT: I will move on to the point that Helen made about time management. Is that just an observation, or has that been confirmed by medical specialists?

Ms Tarbotton: Anecdotally, I have had it confirmed. I cannot say that a medical specialist has put down the time parameters. Women are saying it.

Hon SALLY TALBOT: That is what I am trying to tease out. Is it the report of women who have had that experience?

Ms Tarbotton: Yes. It is through women and the experiences they have shared with me. They feel, for instance, that they are transferred to hospital, and just because they fail to dilate, that is often used as a diagnosis for the next level of intervention to be applied. They feel frustrated by that, because it is known that a hormonal change occurs when a woman is transferred to hospital

and dilation slows until the woman feels comfortable again. It is anecdotal from women who have come to our meetings.

Hon SALLY TALBOT: You have done a stunning job in presenting the kind of evidence that is obviously so necessary to rebalance the arguments that have come from other stakeholders in the field. I am particularly impressed with the dollar values that you have been able to put on things. You have talked about the national hospital cost data collections versus those for WA. Can you put any cost on antenatal care?

Mrs Mansfield: In the hospital?

Hon SALLY TALBOT: You have talked about the fact that for hospital deliveries, the cost does not include antenatal care. Can you put a dollar value on that?

Mrs Mansfield: I will be guessing, but it is about six to 10 visits, usually at the GP.

Ms Bennett: They get it through the midwives, too.

Ms Tarbotton: I only know anecdotally. One birth that ended up being a caesarean section, with four days in a private hospital with an anaesthetist and an obstetrician, equated to around $9 000. Again, that is anecdotal. I do not have all the facts and figures

Mrs Mansfield: One visit was $130 just for the hospital costs. A woman recently came through who was new to the country and did not have Medicare coverage, so she was required to pay for absolutely everything. For her it was $130 a visit on top of what she was paying for her GP, with no bulk-billing.

Hon SALLY TALBOT: We can contact you again through our advisory officer if we need to. You have talked about the fact there must always be two midwives, because that is safe practice. Does a code of practice lay out those standards?

Mrs Mansfield: To be honest, I am not sure. We believe in one midwife for the baby and one for the mother.

Hon SALLY TALBOT: Someone behind us is bursting to tell us the answer. Will you take that question on notice and get back to us?

Ms Tarbotton: I will add to that. When I was homebirthing, my GP was online and we consulted with him on the phone occasionally. Two midwives and a GP were accessible by phone.

Hon SALLY TALBOT: At one stage you said you had read the future directions document and you agree with the recommendations in it.

Ms Tarbotton: I have not read it fully.

Hon SALLY TALBOT: I think it was in your report.

Mrs Mansfield: That is right; I have read through it.

Hon SALLY TALBOT: You are supporting the recommendations for family birthing centres and the like.

Mrs Mansfield: That is right.

Hon SALLY TALBOT: Does that make you feel that your points of view must be getting through, albeit in some mysterious way?

Mrs Mansfield: Yes; everything is looking very positive, I believe, in the current environment. It was very reassuring to read this; it was recognition that midwifery care is respected and valued and the outcomes are confirmed and the government is looking to give birthing back to the local areas. More and more local hospitals are shutting down, the maternity services are shutting down and GPs are pulling out. Bunbury Regional Hospital is getting more and more women from outlying areas. It is regularly overflowing. Bunbury Regional Hospital has 10 postnatal beds. Quite often we run

at 130 or 140 per cent capacity and are overflowing onto the medical ward. A birthing centre would benefit the hospital greatly by taking off that little bit of pressure. It would enable everyone to do their jobs properly. As a hospital midwife, I sometimes go home frustrated because there are too many people to care for to allow us to do our job properly, and it is a job that requires time to do well.

Hon ANTHONY FELS: What happens when you attend a potentially low-risk birth at home and suddenly something goes wrong and blood pressure takes off or whatever and it turns into a potential emergency or emergency caesarean? What do you do in that situation? You talked about Donnybrook and Bridgetown and places like that where assistance should be available. Are you talking about mothers being able to come to Bunbury for midwifery service or are you talking about providing a service out there? In that case, what happens if in that emergency a GP or an obstetrician is not on hand?

Ms Tarbotton: As a homebirther, I can say that women such as me have read a lot and empowered themselves to a high degree. We are very well educated in the birthing process. We would know well before things reached emergency status, if you want to call it that, that the situation required hospitalisation. Also, generally, we are about 15 or 20 minutes away from a hospital. Homebirthing people are not high risk takers. They think very carefully through their decision to homebirth. This is anecdotal, but preparation in a hospital setting for an emergency caesar takes up to 20 minutes. The time involved in making the phone call to the hospital that the mother is on her way in, is probably equal to the time it takes to get ready for an emergency caesar in a hospital setting anyway. Hormonally, the birthing mother shuts down. Her system basically goes into fright and flight mode in which everything slows right down. Her system is protecting herself and her baby. Once she is in the safety of the hospital, she would be once again taken care of. She will have phoned ahead that it is an emergency situation and she will be put straight into theatre. Homebirthing families do not take unnecessary risks. We are not about risking our lives or our babies' lives. We are very careful about that. In the natural homebirthing situation, mothers are under one-on-one monitoring on a very intimate basis. You must understand that all the other aspects that can interfere with the birthing experience and turn it into an emergency situation are limited because of the homebirthing environment.

Mrs Mansfield: From a midwifery perspective, we do not wait until the situation has reached dire straits. The first sign of anything deviating from the norm or any level of concern, we would ring the woman's GP and keep him informed of the progress. If he felt and we felt that it was not safe to stay at home, we would transfer to the hospital and he would meet us there. Once we got to the hospital, the GP would take over the care and manage what needed to be done. If it is beyond his scope, he would refer to the specialist obstetricians on call and they would take it from there.

Hon ANTHONY FELS: Are trained midwives in the community, or is there a limitation on the numbers for this sort of model?

Mrs Mansfield: I think there are more than enough. There are certainly enough midwives desperate to work in the community. A couple of years ago we had trouble staffing the maternity unit, but we seem to be going along nicely at the moment. We have plenty of midwives on the casual lists.

Ms Bennett: There are six in Margaret River and another two are coming. The number is growing. Approximately 10 girls are doularing, which is great for antenatal and postnatal preparation and care.

Ms Tarbotton: If there was a change in the approach to liability, more midwives would be prepared to support homebirthing or even employment within the hospital setting.

Mrs Mansfield: Bunbury Regional Hospital supports midwifery students through Curtin University. Each six months a new midwife graduate through the hospital and then stays on and

works as part of the staff in a postgraduate-employed position, and inevitably they obtain permanent employment.

Hon ANTHONY FELS: Is that situation reflected throughout Western Australia or more locally?

Mrs Mansfield: I am not sure, to be honest.

Ms Bennett: I cannot say.

The CHAIRMAN: We will have to wind up. I thank you again for the wonderful preparation you have done and it is fantastic to have tabled all the letters from individual people. Thank you very much.

Hearing concluded at 12.43 pm