

From: [REDACTED]
To: [REDACTED]
Subject: Public consultation - Member of the community
Date: Friday, 10 March 2017 1:45:16 PM

Dear Ms Newbery,

Thank you for the opportunity to comment on the draft Code of Conduct for midwives in Australia.

I have been lucky to have experienced some wonderful, life-affirming and life-changing midwifery care in support of the birth of my second child in particular. Unfortunately, I have also experienced manipulation and coercion in maternity care that has been physically harmful, costly, profoundly distressing and would be contrary to the laws of assault and my rights to respectful health care and personal autonomy. Australian legal remedies are not adequate to address these problems, even if any new mother had the time and energy to pursue them, especially as no remedy can replace precious lost moments.

I value the commitment of midwives to a culture and practice of respectful, skilled, truly collaborative care and trust that revisions to this code will tackle the difficult issues in maternity practice to set those standards.

Yours sincerely,

Monica Murfett

Comments and suggestions in relation to the seven principles outlined in the draft Code of Conduct for midwives in Australia

The draft code does not yet adequately 'acknowledge pregnancy, birth and parenting as significant life events for women' and accommodate the 'wellness paradigm' as outlined in the National Maternity Service Plan 2010, p25. These are fundamental to the nature of midwifery, and need to be incorporated into the principles: a mention in the foreword won't do. Without detracting from the importance of cultural sensitivity expected in relation to people of Aboriginal or Torres Strait Islander descent, I would suggest the significance of pregnancy, birth and parenting be affirmed as an aspect of cultural sensitivity or cultural safety (in 3.2) for *women as women*, regardless of their ethnic background. This is particularly necessary to counter a threat or perception of medicalisation of birth that has been an issue at least since the Maternity Services Review. Reference to the wellness paradigm would be appropriate in 2.1 and/or 7.2.

a. Lawful behavior

--[if !supportLists]-->• <!--[endif]-->I suggest omitting 1.2(a): it is redundant or within the scope of 1.2(d); it sets a very low impression of the standard expected of midwives; and seems to miss the point of the midwife-woman relationship.

--[if !supportLists]-->• <!--[endif]-->4.1(i) 'not participate in physical assault (such as striking, unauthorised restraining and/or applying unnecessary force)' belongs in 1.2, not

4.1 – preferably as 1.2(a). ‘Cutting’ (or at least ‘unlawful cutting’) should also be included in this list, to be clear about unwanted episiotomies etc.

• 1.3(a) should be moved to be a subparagraph of 1.2; the lead paragraph of 1.3 and 1.3(b) should be omitted. Although the lead paragraph of 1.3 is useful in the ‘children and young people’ context of the Shared Code of Conduct and reasonably well adapted to the nursing context in the Code of Conduct for nurses, it is not useful as a separate explanation in 1.3 of the draft Code, and potentially implies or promotes conflict between the midwife, woman and infant. Vague reference to ‘those groups’ in 1.3(b) would seem to blur the line between (good) discretion and (illegal) discrimination, contrary to the omitted paragraph 2.4 of the Shared Code.

b. Information and consent

The information provided on informed consent is not clear or accurate, especially the heading and lead paragraph, and should be restructured. Reference to the ‘right to informed consent’ (in 2.3) is not one right, but inappropriately conflates several of the separate rights under the Australian Charter of Healthcare Rights as well as related rights at common law. ‘Consent’ is relevant at common law as a defence to the tort of assault. The duty to inform a patient before they consent to an action or treatment is an aspect of the professional duty of care, breach of which would be professional negligence. Although the terms are related and often appropriately used together (even by the Australian Law Reform Commission), when conflated they can inappropriately imply that consent (or refusal of consent) is not valid unless it is fully informed, and confuse Australian law with US law on informed consent.

The separate treatment of the duty to inform (under the communication heading) and consent in the shared code of conduct template is better than combining them under the heading of informed consent. Alternatively, if other consultations suggest a strong preference for combining the two, one way I would suggest that code would provide clearer and more useful guidance to midwives if the heading and lead paragraph of 2.3 focused on ‘information and consent’.

For similar reasons, I would suggest omitting ‘informed’ from 3.5(a).

Para 2.3(b) should reincorporate ‘investigations’. Women have the right to refuse investigations that they do not want, and omitting reference to them from this primary guidance document for midwives does not help women or midwives.

Paragraph 2.3(c) should be adapted to suit the maternity context, possibly by simply omitting ‘and the nature of the proposed care’.

I see the AMA guidance on Maternal Decision-Making of 2013 as better (though not ideal) guidance for midwives as well as doctors, in individual situations and for setting the standards and changing the culture of maternity care. I request you consider incorporating similar language into this code, or otherwise making it applicable to midwives.

Birth planning is a normal expectation of pregnant women, preferably in consultation with their maternity care provider/s, whether or not they and their maternity care provider/s prefer to record plans or preferences in writing. By using ‘plans or preferences’ in this context I do not mean to understate the significance of ‘preferences’

to consent or imply inflexibility of 'plans'. I propose inserting 'When requested, facilitate birth planning', probably after 2.2(f) or before 2.3(d). This is drawn and adapted from end-of-life care section of the Shared Code of Conduct and Code of Conduct for Doctors. This is an aspect of antenatal care, health education and building health literacy; it is not new; it provides reasonable clarity and flexibility and it adapts the Shared Code of Conduct to midwifery practice.

c. Other issues covered in the Shared Code of Conduct

Several headings have been omitted from the Shared Code of Conduct template, that are not adequately addressed in other modifications to the draft Code for midwives or other standard setting documents that I am aware of. This inconsistency from the codes for other health profession is odd at least, and worrying given that they are highly relevant to contentious issues in maternity care. Simply avoiding contentious issues in this draft Code is not helpful for midwives, women or babies.

<!--[if !supportLists]-->• <!--[endif]-->I propose that you reincorporate 2.4 'decisions about access to care', notably the last clause of 2.4(d), though I would imagine that (e) and (f) may be less relevant than (a) – (d). Clauses about discrimination in 3.2 and 3.4 of the draft code do not address discrimination as adequately or directly as 2.4(c) of the Shared Code.

<!--[if !supportLists]-->• <!--[endif]-->Similarly the abrogation of 'principles of good care' from 2.1 (a)-(e) of the Shared Code of Conduct to a substantially lower standard in 2.1 and 2.2(d) of the draft code is hostile to the standard of care that many women expect of midwives, whether they are employed or in private practice. It is contrary to evidence of the benefits of continuity of care (or expressed inversely, poorer outcomes for women and babies who experience discontinuities in their care).

<!--[if !supportLists]-->• <!--[endif]-->6.1, especially 6.1(a), is an inadequate replacement for the coverage of research ethics usefully given in 11.2 of the Shared Code. New Zealand's experience of cervical cancer research and training practices on unconsenting women is not so far away in time or space that clear statement of these basic ethics is unnecessary in a professional code of conduct.

<!--[if !supportLists]-->• <!--[endif]-->9.2(c) of the Shared Code or 9.2.3 of the code applicable to doctors are better worded than 7.1(a) of the draft Code of Conduct for midwives, for clarity that those apply to the practitioner's own health rather than patients' health.

<!--[if !supportLists]-->• <!--[endif]-->8.8 of the Shared Code is necessary and applicable to midwifery practice. Among other aspects, women routinely require medical certificates for employment purposes.

Midwifery code: 'person', 'woman', or another term?

The midwifery code should refer primarily to 'woman'. Removing 'women' from midwifery policy documents is simply absurd, and suggests that regulation of midwifery has lost focus on 'with woman' care altogether. Referring to 'women' as such is necessary to recognise the 'centrality of the relationship with women to the practice of

midwifery', per the competency standards.

Rather than replacing all instances of 'person' with 'woman', some sections of the document (e.g. 2.2(b) and 5.2(a)) need to be thoughtfully reviewed to accommodate infants as subjects of midwifery care. For those non-clinical contexts in which midwives practise, the document should be reviewed to accommodate children, clients or other people where that is relevant, but without removing references to women indiscriminately. To accommodate those people who are pregnant or giving birth but do not identify as women, I propose that your note/glossary acknowledge such people, and advise midwives to use their respect and good judgment to use alternative pronouns etc as appropriate.

Is 'professional relationship' the best description?

No. 'Partnership' was a better term: to acknowledge the dignity, humanity and agency of the woman, to acknowledge the intensely personal nature of the relationship for the woman, and to help mitigate the power imbalance women experience in institutional maternity settings. Preference for 'partnership', and avoids the commercial or transactional connotations of 'professional relationship'. 'Partnership' does not detract from the high regard for midwives' professional skills, ethics, aspirations, experience, or capacity for objectivity. Professionalism is (and boundaries are) still expected, and reference to professional relationships may be appropriate in some parts of the document.

How should the NMBA promote awareness of the new Codes to nurses, midwives, other health professionals, employers, educators and the public?

I have nothing to add on this issue.