fact sheet 2

Before You Start

Before your start:

- obtain relevant information about the committee, its structure, scope of activity, authority and method of operation;
- find out the committee's terms of reference;
- what financial assistance you can expect;
- who the other committee members are;
- relevant reports and reviews;
- meeting timetables and procedures;
- duration of the committee;
- plan and establish long term goals; and
- find out about the expected workload.

Before meetings:

- read over your long term goals;
- set short-term goals for the meeting;
- gather consumer views on the issues;
- obtain a briefing from your nominating organisation or other consumer groups or other individuals;
- check the minutes of the last meeting;
- participate in committee meetings by submitting agenda items, look at the agenda and minutes of the last meeting; and
- highlight any achievable goals, so you can tackle them early on.

At meetings:

- if necessary, have the previous meeting's minutes amended;
- add items to the agenda;
- keep the committee to its objectives;
- take notes of any significant points and major decisions;
- support the consumer perspective;
- use lunch-breaks to chat informally and ask questions; and
- watch out for possible allies and foes.

Between and after meetings:

- report to your organisation;
- re-charge your batteries;
- keep in contact with the secretary and other committee members;
- reflect and evaluate your work on the committee; and
- monitor the progress of the committee.

Understanding Evidence

Abstract	An abstract is a concise summary found in many journal articles. It summarises the aim, methods, results and conclusions of the study.
Blind trials	• Single-blind trial In a single-blind trial, the researcher knows the details of the treatment but the patient does not. Because the patient does not know which treatment is being administered (the new treatment or another treatment) there might be no placebo effect. In practice, since the researcher knows, it is possible for him to treat the patient differently or to subconsciously hint to the patient important treatment-related details, thus influencing the outcome of the study. • Double-blind trial In a double-blind trial, one researcher allocates a series of numbers to 'new treatment' or 'old treatment'. The second researcher is told the numbers, but not what they have been allocated to. Since the second researcher does not know, he cannot possibly tell the patient, directly or otherwise, and cannot give in to patient pressure to give him the new treatment. In this system, there is also often a more realistic distribution of sexes and ages of patients. Therefore double-blind (or randomized) trials are preferred, as they tend to give the most accurate results. • Triple-blind trial Some randomized controlled trials are considered triple-blinded, although the meaning of this may vary according to the exact study design. The most common meaning is that the subject, researcher and person administering the treatment (often a pharmacist) are blinded to what is being given. Alternately, it may mean that the patient, researcher and statistician are blinded. These additional precautions are often in place with the more commonly accepted term "double blind trials", and thus the term "triple-blinded" is infrequently used. However, it connotes an additional layer of security to prevent undue influence of study results by anyone directly involved with the study. (source: Wikipedia).
Clinical Guidelines	In Queensland, Clinical Guidelines have been developed to support a standard approach to clinical care across Queensland. There is a growing collection of guidelines that advise clinicians how women should be cared for in particular circumstances. They are described as "evidence informed consensus guidelines" and draw from the evidence base, existing national and international guidelines and the expert opinion of the working party (www.health.qld.gov.au/cpic/resources/mat_guidelines.asp). The working party may or may not have included consumer representatives in the development of each clinical guideline. Although evidence-based care is the gold standard, these guidelines do not meet that standard. This is because sometimes there is not sufficient evidence available, or more commonly, working party members can't agree on how to interpret the evidence. In these cases, expert consensus is used in place of evidence.
Literature Review	A literature review brings together all kinds of reports relevant to a particular topic and summarises them. It might include RCTs, other kinds of research projects, other literature reviews and other kinds of published information (media, opinion articles, clinical guidelines etc). It identify gaps in the existing body of knowledge (things we don't know), as well as areas of consensus (things we agree about) and areas of

	conflict (things we disagree about).
Meta-analysis	A meta-analysis involves the combining together and subsequent analysis of results from more than one trial. This can be done without a full systematic review, however, although such a meta-analysis will have greater mathematical precision than an analysis of any one of the component trials, it will be subject to any biases that arise from the study selection process, and may produce a mathematically precise, but clinically misleading, result. (Source: www.thecochranelibrary.com)
Peer-reviewed journal	A journal whose articles have been through a process of examination by experts in the field to determine that the studies on which they report had valid findings and were based on valid and ethical methods of investigation. Not all journals are peer-reviewed, and sometimes there are interesting conflicts between who is on the peer-review panel and the kind of articles that are published in the journals and the opinions expressed.
Randomised Controlled Trial	A randomized controlled trial (RCT) is a type of scientific experiment most commonly used in testing the efficacy or effectiveness of healthcare services (such as medicine or nursing) or health technologies (such as pharmaceuticals, medical devices or surgery). RCTs involve the random allocation of different interventions (treatments or conditions) to subjects. This ensures that both known and unknown confounding factors are evenly distributed between treatment groups. In maternity research, RCTs are highly problematic and therefore very rare. It isn't ethical to conduct an RCT where there are known benefits of one treatment (eg continuity of carer) over another because it allocates one group to receive lesser standard of care. Beyond that, it is unlikely women would consent to being having their choices randomly dictated in a trial – eg whether or not they are able to access water immersion in birth, or whether they have the option of vaginal birth after caesarean.
Systematic review	To help identify which forms of health care work, which do not, and which are even harmful, results from similar randomized trials need to be brought together. Trials need to be assessed and those that are good enough can be combined to produce both a more statistically reliable result and one that can be more easily applied in other settings. This combination of trials needs to be done in as reliable a way as possible. It needs to be systematic. A systematic review uses a predefined, explicit methodology. The methods used include steps to minimize bias in all parts of the process: identifying relevant studies, selecting them for inclusion, and collecting and combining their data. Studies should be sought regardless of their results.

fact sheet 3

Dollars and Sense - Resource Checklist

Other committee members and the committee secretariat often have all the money and you, the consumer representative, have all the common sense. This resource checklist is to remind you of some of the resources you can get from them as they get the benefit of your common sense:

- sitting fees – paid to you while you attend meetings;
- travel costs – usually cover airfares and taxis;
- phone calls – cover costs of consulting and other committee related activities;
- photocopying – secretariat will do this or reimburse you to do it;
- postage and faxes – cover the cost of consulting and sending working drafts out for discussion;
- expenses for people with disabilities – can cover carers, special phones, talking computers, and agenda papers in large print;
- copies of articles;
- searches for books;
- arrange telephone conferences;
- provide some limited typing support;
- training courses;
- definitions and explanations of technical terms; and
- modem to provide e-mail access.

It is not realistic to expect to obtain all of the above resources, some secretariats simply do not have the resources to support you as you deserve. This list is by no means exhaustive but it is to give you an idea of the sort of support you could try asking for. Try to use your imagination, if you fail to successfully lobby for sitting fees, try to at least get your expenses paid.

Reasons for getting the loot:

- you are attending committee meetings in a volunteer capacity, it is not part of your work;
- most other committee members have access to phones, photocopiers, faxes, email and computers which makes committee life much more bearable for them;
- most other committee members have an allowance from their work to cover accommodation, taxis and meals;
- most other committee members have work colleagues on the committee to discuss issues with so they do not need to consult as widely or as extensively as consumer representatives; and
- most other committee members are supported by organisations which are well resourced unlike most consumer representatives whose organisations are often poorly resourced in comparison.

fact sheet

4

Common Problems and Solutions

Your agenda papers are incomplete:
- ask for a copy of the paper; and
- ask for any important items to be deferred until you've looked at them.

The agenda papers were late:
- ask the Secretariat why the papers were late; and
- if its more than a one-off situation, and the Secretariat is not fixing the situation, have a word with the Chairperson.

Jargon
- get committee members to explain the jargon; and
- get the secretariat to provide you with a list of commonly used words or acronyms.

Having problems getting heard
- create a positive first impression;
- refer to the committee standing orders or agreed procedures and track down the debate rules. Often a person can only speak once in a debate;
- whenever you speak articulate your point or argument well;
- change your seating so you can catch the chairperson's eye better; and
- try not to out-shout someone.

You are locked in a stalemate:
- take the initiative; and
- change the game.

You disagree with a major decision
- refer to your nominating organisation for support.

Agreement is reached but nothing's done
- follow up so it gets done.

A previous agreement is re-discussed
- refer back to previous minutes and bring this to the attention of the committee.

Accountability
- belong to a consumer organisation;
- report back to your nominating group; and
- consult with the wider consumer movement - you have access to information that other committee members do not.

Confidentiality
- seek advice from your nominating organisation;
- discuss confidentiality issues with the Chairperson; and
- discuss with the committee or the Chairperson your reporting responsibilities.

Conflict of Interest
- consult with your nominating organisation.

Public Statements
- consult with your nominating organisation.

Isolation
- establish networks with other consumer representatives and groups;
- keep in regular contact with your nominating organisation; and
- keep in contact with other committee members (if appropriate).

Directorships of incorporated entities
- ask the secretariat about your liability and appropriate insurance.

fact sheet 5

Effective Representation - You're OK

- have a positive and realistic outlook;
- present your argument rationally and convincingly;
- negotiate;
- plan what issues you are going to tackle on behalf of consumers;
- create a positive first impression;
- analyse issues and judge their effects on consumers;
- present the consumer perspective not your own personal view;
- plan your tactics;
- speak with potential allies;
- caucus with other committee members;
- consult with your constituency;
- network with other consumer representatives;
- report regularly to your nominating organisation;
- keep in control;
- don't bargain over positions;
- ensure everyone is committed to the outcomes;
- use agreed-upon criteria;
- improve your skills; and
- use your skills.

Reporting Back to Your Organisation

If your organization doesn't have an accepted format for reporting back the progress of your committee, this template may be useful to you. You need only complete the relevant sections. Remember to mark it CONFIDENTIAL as necessary. Electronic copies of this form will be available in the future.

Committee Name:	
Report from:	
Report to:	

Details of meeting

Date:		Duration:	
Frequency:			
Attendance:	teleconference in person other: _____		
Meeting/forum purpose:	(short description, key outcomes)		
Reimbursements:	(eg sitting fee, parking, childcare)		
Key attendees	Name	Role	
Internal staff:			
Consumers:			
Guest speakers/one off attendees etc:			
Summary:	(break throughs, highlights, bombshells or highly contentious points)		
Agenda items:			
Literature collected:			
Additional items/ discussions/ decisions etc:			
Tentative next meeting:	Date: Agenda:		
Questions	(for my consumer organization)		
Miscellaneous:			

Invoice

_____
Date

From:

_____
_____
_____
_____

To:

_____
_____
_____
_____

1. Payment is requested for:

2. Please make the payment directly to my bank account **Amount:** _____
   - Account number: _____
   - BSB: _____
   - Account name: _____

Thank you.

_____

Tax file number: _____
ABN: _____

Sample Letter to District CEO

56 Main St
BRISBANE Qld 4001

Your address on the top left

2 July 2011

The date you are writing the letter

Prof Keith McNeil
PO Box 150
RBWH Post Office
HERSTON QLD 4029

The recipients full name and address, also on the left. Check the directory in your MCRP folder.

Dear Professor McNeil

Begin with a courteous salutation. Use the person's formal name and title.

I am participating in Queensland Centre for Mothers and Babies' maternity consumer representatives training program and, as part of that, I would welcome the opportunity to become a consumer representative at my local hospital, Caboolture Hospital. I became passionate about woman-centred maternity care after the empowered births of my own children, in a continuity model of care.

Introduce yourself and the reasons for your letter.

I am aware that the Queensland Health Minister has set a target for the expansion of continuity of midwifery carer models in Queensland public hospitals and am keen to find out what is planned at Caboolture Hospital to meet this target. I believe it is important that consumer representatives such as myself are involved in hospital committees that oversee the development and maintenance of maternity services as this can help ensure that these services respond to the needs of the communities they serve.

Next expand on the reason for your letter.

Can you please advise me what is planned for Caboolture Hospital's midwifery continuity of carer target? In particular, I would welcome your advice about how I can best become involved in this process. I can be contacted on janesmith@gmail.com or phone XXXX XXX XXX.

Finish with a request for some action on the part of the recipient. This is a good place to include other contact details as well.

Sincerely,

Jane Smith

And a polite closing. Don't forget to sign your letter.

Guest Editorial, By Ann Catchlove for 'Birth Matters', journal of Maternity Coalition.

Informed choice, consent and the law: the legalities of "yes I can" and "no I won't"

Informed decision making as a human right

Being able to make decisions about what happens to our bodies is a basic human right – it goes to an individual's fundamental autonomy, dignity and bodily integrity, as reflected in article 3 of the Universal Declaration of Human Rights, which states that "everyone has the right to life, liberty and security of person."

To give someone medical treatment without their consent interferes with their dignity and security of person and, while international human rights law does not expressly prohibit this, it is regarded as implicit. Cases concerning the administration of medical treatment without consent have been considered under the sections of the International Covenant on Civil and Political Rights which deal with inhuman or degrading treatment (article 7), liberty and security (article 9) and privacy (article 17).

In Victoria and the ACT, the right to informed consent to medical treatment has been enshrined in human rights legislation. Section 10(2) of the ACT Human Rights Act protects individuals from being subjected to medical treatment without their "free consent". Section 10(c) of the Victorian Charter of Human Rights and Responsibilities is even more comprehensive in prohibiting medical treatment without "full, free and informed consent".

Informed decision making as a legal right

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

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

Consent in the context of assault only requires a consumer to understand the broad nature of the proposed treatment, however a care provider risks an action in negligence if he or she does not present adequate information to enable the consumer to make an informed decision. The High Court in the case of *Rogers v Whittaker* (1992) 175 CLR 479 referred to "the paramount consideration that a person is entitled to make his own decisions about his life" and found that:

> The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be

Respecting a woman's decision-making autonomy also means that a woman must not feel that she is being coerced into making a particular decision. Coercion also puts a care provider at risk in any legal claim where consent is an issue. Many women report that they feel coerced into making decisions to have interventions during pregnancy and childbirth. The clearest example of coercion is perhaps when a woman is told that her baby will die or be severely disabled if she fails to agree to a particular course of action. Less obvious examples that nonetheless impact on a woman's ability to make free decisions include being forced to make decisions quickly in non-emergency situations or being told she will not have access to a particular model of care if she fails to agree to certain screening tests or other procedures.

Maternity care is no different to any other area of healthcare. Pregnant women have the same human rights and legal rights as everyone else. They have the right to give or refuse consent to medical procedures and to be given the information that they need to make their own informed decisions. Careproviders (and women themselves) must have a comprehensive understanding of these concepts not only to ensure that rights are respected and the law followed but so that women are able to make the best possible decisions for themselves and their babies.

Ann Catchlove is a solicitor, mother of two and the President of the Victorian branch of Maternity Coalition. Her interest in informed decision making stems from her own poorly informed decision to consent to an emergency caesarean for her first birth. She made an informed choice to have a VBAC for her second birth.

"National Maternity Services Plan"
Australian Health Ministers Advisory Council (2011). National Maternity Services Plan.

http://www.health.gov.au/internet/main/publishing.nsf/Content/349C976EEDDB5EB0CA257862001B3657/$File/National%20Maternity%20Services%20Plan%20Feb%202011.pdf

- Sets out a five year vision for maternity care in Australia (including breaking vision into early, middle and later components):
  - Maternity care will be woman centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.

- Although it fails to set a target for expanding women's access to continuity of midwifery carer. Instead it establishes a range of priorities (again, not measurable targets that must be met within a certain timeframe):
  - **Access**: to information; range of models of care; for women in rural and remote areas.
  - **Service delivery**: high quality, evidence-based maternity care; culturally competent care for Aboriginal and Torres Strait Islander women; services for women who have medical, socio-economic or other risk factors.
  - **Workforce**: woman-centred care within a wellness paradigm; Aboriginal and Torres Strait Islander workforce; rural and remote workforce; culture of interdisciplinary collaboration.
  - **Infrastructure**: Safety and quality system; service planning, design and implementation is woman-centred.

- The lack of targets means that it lacks the levers to ensure that state-based public maternity services will act to implement the required changes. In other words, there is no carrot and/or stick approach to ensure women receive the intended improved range of choices or quality of care.

"Collaborative Guidance"
National Health and Medical Research Council (NHMRC) (2010). National Guidance on Collaborative Maternity Care.

http://www.nhmrc.gov.au/publications/synopses/cp124syn.htm

- NHMRC was commissioned by the government to develop the *Collaborative Guidance* as part of the national maternity reform process. Despite its many strong points, it has so far had little impact in either the care women receive or the collaboration among women's carers. Nonetheless it contains some useful gems for consumer reps.
- Establishes key definitions:
  - **Collaboration**: a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care. Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman's care, especially for the person the woman sees as her maternity care coordinator. (NB. This is a different idea to that of a 'Collaborative Arrangement', which is a requirement of the national reforms dictating that an eligible midwife in private practice needs in order for her clients to receive Medicare rebates for their care.)
  - **Informed choice** occurs when a woman has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all the options for her care, in the absence of coercion or withholding any options by any party.
  - **Informed consent** is when a woman consents to a recommendation about her care, in the context of informed choice, that reflects self-determination, autonomy and control.
  - **Informed refusal** is when a woman refuses a recommendation about her care, in the context of informed choice, so that she can make a decision that reflects self-determination, autonomy and control.
  - **Woman-centred care** is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self determination in terms of choice, control and continuity of care.
- Established 9 principles of collaborative maternity care:
  - Maternity care collaboration places the woman at the centre of her own care, while supporting the professionals who are caring for her (her carers). Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial and clinical needs.
  - Collaboration enables women to choose care that is based on the best evidence and is appropriate for themselves and for their local environment.
  - Collaboration enables women to make informed decisions by ensuring that they are given information about all of their options. This information should be based on the best evidence, and agreed to and endorsed by professional and consumer groups.
  - Collaborating professionals, regardless of the model of care, establish a clearly defined and inclusive reciprocal communication strategy using sensitive language to support professional trust.
  - Collaboration has an underpinning safety and quality framework that includes monitoring health outcomes for mothers and babies, regular multidisciplinary discussions about how the collaboration is working (involving women who have used the service) and public reporting.
  - Collaborating professionals respect and value each other's roles, provide support to each other in their work and provide education to meet each other's needs.
  - Collaboration is committed to joint education and training, following a consistent, agreed care plan and research focused on improving outcomes.
  - Collaboration aims to maximise a woman's continuity of care and carer, throughout pregnancy, birth and the early postnatal period.
  - Collaboration aims to maximise a woman's continuity of carer by providing a clear description of roles and responsibilities to support the person that a woman nominates to coordinate her care (her 'maternity care coordinator').

"Primary Maternity Services Framework"
Australian Health Ministers Advisory Council (AHMAC) (2008). Primary Maternity Services Framework.

http://www.ahmac.gov.au/cms_documents/Primary%20Maternity%20Services%20in%20Australia.pdf

Statement of committee by Australia's health ministers (all the state, Territory and Federal Health Ministers) to recognise maternity care as a primary health care service. Key points include:

- Commitment to extending and enhancing primary maternity service models as a preferred approach to providing pregnancy and birthing services to women with uncomplicated pregnancies.
- Women must be the focus of maternity care. They should be able to feel they are in control of what is happening during pregnancy and childbirth, based on their individual needs and having discussed issues fully with their care providers.
- The underpinning philosophy of primary maternity services is that birth is a normal but significant physiological event and that different women have different needs in relation to pregnancy and childbirth. Pregnancy and childbirth, while requiring quick and highly specialised responses to complications and emergency situations, is a normal physiological process, not an illness or disease.
- Primary maternity services may be provided in public maternity units, birth centres, in the community or in a combination of these settings. Care includes antenatal, birthing, and postnatal care for women with low-risk pregnancies.
- Safety and effectiveness of primary maternity services is underpinned by collaboration.
- By enabling midwives to work to the full scope of their midwifery skills, women will have the opportunity to be provided with the type of care they are increasingly demanding.
- The availability of a consistent carer who is involved in, and familiar with, the woman's antenatal care enables better provision of care in the birthing and post-natal period.

Defines primary, secondary and tertiary maternity care:

- The best primary maternity services demonstrate the following features:
  - High quality care enabled by evidence-based practice
  - Care is coordinated according to the woman's clinical need
  - Health professionals work together in a collaborative multidisciplinary approach
  - Continuity of care through pregnancy, birth and the early postnatal period
  - Enable woman-centred care which gives women a sense of control of their birthing experience
  - Care is culturally appropriate and reduces health inequalities
  - Enable continued access to best practice care at the local level.
- Secondary maternity services meet the needs of women who have higher risk pregnancies, or who develop complications and require transfer to more specialist secondary level input or referral to specialist medical care.
- Tertiary maternity services are vital to provide multidisciplinary specialist care for women and babies with complex and/or rare fetal–maternal needs.
- Midwives will still be involved in providing both a supportive role and clinical care in secondary and tertiary care.

"ACM Guidelines"

Australian College of Midwives (2008). National Midwifery Guidelines for Consultation and Referral (2nd edition).

http://midwives.rentsoft.biz/lib/pdf/Consultation%20and%20Referral%20Guidelines%202010.pdf

- Provides a single, nationally consistent and evidence-informed framework to assist midwives to make decisions, in consultation with the woman receiving care, about when to discuss care with other midwives, and/or to consult with or transfer a women's care to a suitably qualified doctor.
- Recently endorsed by Queensland Health for use in all Queensland Health midwifery models of care.
- Based on a set of core assumptions informed by international standards and best practice in maternity care:
    - Pregnancy, birth and the postnatal period are normal physiological processes.
    - Maternity care must be based on awareness of physical, emotional, social and cultural aspects of wellbeing for both the woman and her infant(s).
    - The achievement of collaboration and co-operation between the professional groups involved in maternity care is of major importance for optimal care. This involves recognition of the particular expertise found within the various groups of health care-providers.
    - The woman and the midwife work together during the whole maternity experience, building a relationship of trust with each other, sharing information and decision making and recognising the active role that both play in the woman's maternity care.
    - Where a woman has selected a midwife for her care, the referral to secondary or tertiary level maternity care is carried out by the midwife (primary level caregiver), who is qualified for this task.
    - Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care or support to the woman.
    - In order to ensure that selection and referral take place appropriately, the expertise of the secondary and/or tertiary level health care-providers must be accessible to the midwife by means of consultation and advice.
- Describes clinical indications for when a midwife should:
    - Discuss a situation with a colleague (another midwife, and/or with a medical colleague or other health care provider)
    - Consult with a medical or other health care provider
    - Refer a woman or her baby to secondary or tertiary care.
- Protects the principles of informed choice and informed consent, including with the provision of *"Appendix A: When a woman chooses care outside the recommendations of the ACM Guidelines"* which clearly spells out the midwives duty of care to the woman, even where a woman's choices are significantly outside the midwife's advice.

- Are sometimes used as the basis of exclusion criteria from midwifery models of care, by applying them as a risk stratification tools for women. In fact, the risk categories in the *Guidelines* describe the appropriate courses of action for midwives in particular clinical circumstances (rather than characteristics of women).

Sources of Evidence

Queensland Centre for Mothers and Babies www.qcmb.org.au; www.havingababy.org.au

The Queensland Centre for Mothers & Babies (QCMB) is an independent research centre based at The University of Queensland. The role of the QCMB is to work towards consumer-focused maternity care that is integrated, evidence-based and provides optimal choices for women in Queensland. Research projects and resources developed by the Centre are available on the website (http://www.qcmb.org.au/publications_and_reports/menu/publications_downloads).

Additionally, requests for documents of supporting evidence can be made to QCMB via the Marketing/Communications Manager, Andrew Dunne (a.dunne@uq.edu.au) if required.

Childbirth Connection www.childbirthconnection.org

Childbirth Connection a US not-for-profit organization founded in 1918. They aim to improve the quality of maternity care through research, education, advocacy and policy. Childbirth Connection promotes safe, effective and satisfying evidence-based maternity care and is a voice for the needs and interests of childbearing families. Their website contains up-to-date evidence-based information and resources for clinicians and women & families on planning for pregnancy, labour and birth, and the postnatal period.

Cochrane Library www.thecochranelibrary.com

A freely searchable online database of 'systematic reviews' conducted by The Cochrane Collaboration. Systematic reviews are often held up as the 'gold standard' of evidence in health care because they combine results from multiple randomised controlled trial (RCTs) to produce findings that are considered more statistically reliable. Abstracts of Cochrane Reviews include summaries in plain language.

MIDIRS (Midwives Information and Resource Service) - www.choicesforbirth.org/information.php

A UK website with accurate, reliable and objective information; based on the very best available research evidence. Full leaflets are available for consumers and professionals (only these contain references) and both must be paid for. Maternity Coalition has full hard copy of both sets from 2005.

Pubmed - www.ncbi.nlm.nih.gov

PubMed is a service of the U.S. National Library of Medicine that includes over 18 million citations from MEDLINE and other life science journals for biomedical articles back to the 1950s. PubMed includes links to full text articles and other related resources.

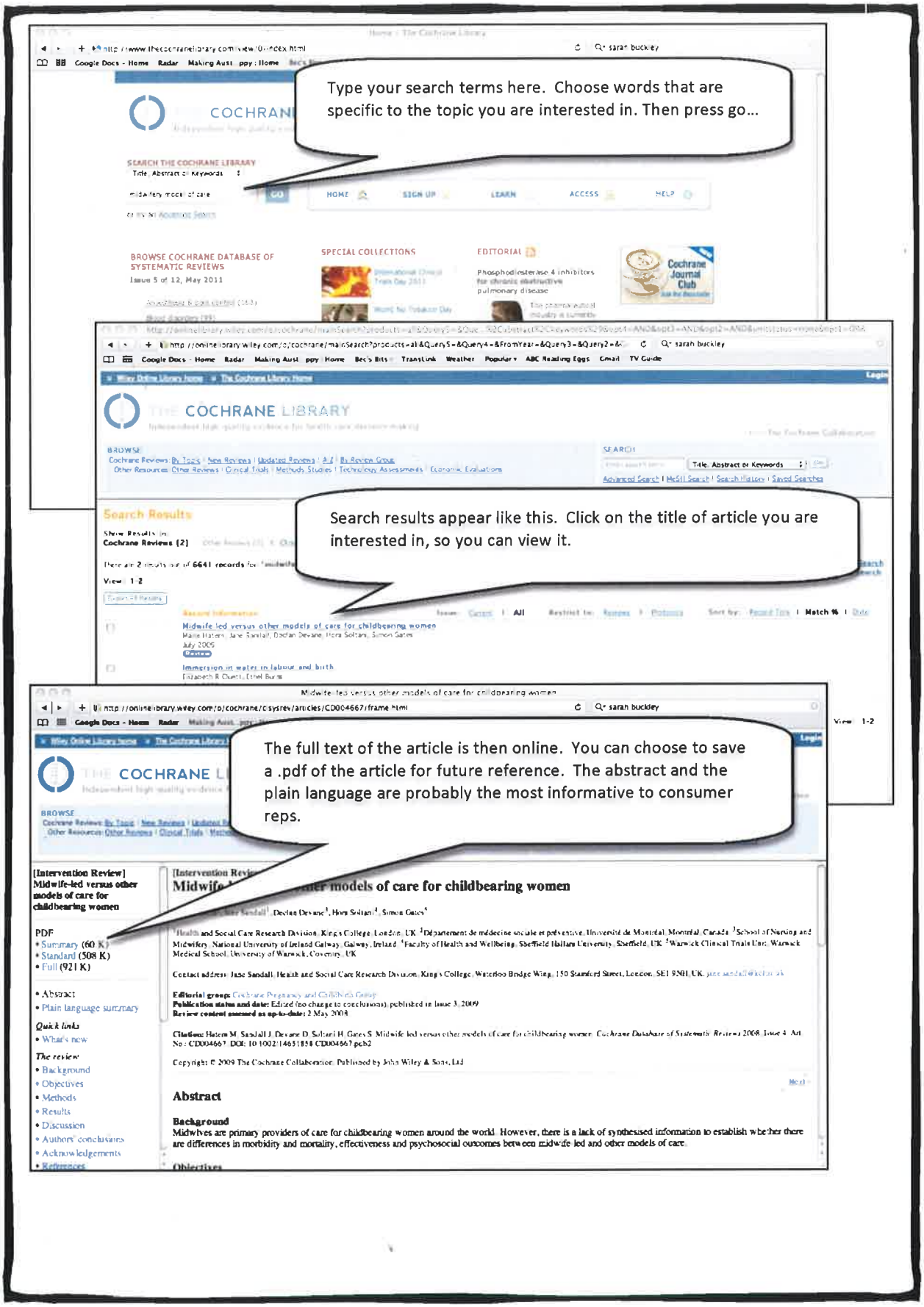
Google Scholar - scholar.google.com.au

A specialised google search engine that locates online journals and article from all disciplines. Some search results are freely accessible online, some abstracts can be accessed and some are not accessible without cost.

Sarah Buckley's articles - www.sarahbuckley.com/articles/

Sarah Buckley is a Brisbane GP who has written the book *Gentle Birth, Gentle Mothering: The wisdom and science of gentle choices in pregnancy, birth, and parenting*. Several of her articles are available online and they include her references.

http://www.sarahjbuckley.com/articles/articles.htm


Type your search terms here. Choose words that are specific to the topic you are interested in. Then press go...
Search results appear like this. Click on the title of article you are interested in, so you can view it.
The full text of the article is then online. You can choose to save a .pdf of the article for future reference. The abstract and the plain language are probably the most informative to consumer reps.
Midwife-led versus other models of care for childbearing women
Abstract
Background
Midwives are primary providers of care for childbearing women around the world. However, there is a lack of synthesised information to establish whether there are differences in morbidity and mortality, effectiveness and psychosocial outcomes between midwife led and other models of care.

Reviewing Documents

Your consumer organisation has asked for your feedback on this document. Take a few minutes to examine the document you have been given. Working individually, decide what feedback you would like give.

Now find the other people in the room who have been looking at the same document as you. Form a group with them and discuss your feedback. Formulate a group response to the document.

Reflect on how your individual feedback grew or changed after discussing it with other consumer reps. Discuss this activity with the whole group.

How evidence is used (and misused)

Each group will be reviewing a different case study of how evidence has been used in the recent past in maternity reform work. Your task is to examine the claims made and then compare it to the evidence itself. Where there are several documents to review, you could divide these among your group members for review. For this activity, it is appropriate to begin by reading the abstract, and skim read the rest of the document as needed.

My case study topic: _____

What are the major claim/s made by the author?

What evidence does that author cite to support that claim?

What does the evidence actually say about that point?

To what extent is there a match between the evidence and the author's claim/s?

As a consumer representative, how could or would you respond to the situation in your case study?

Discuss why there might be disagreement about the conclusions drawn from evidence.