SELECT COMMITTEE ON INTERVENTION IN CHILDBIRTH

REPORT

Presented by:
Dr Hilda Turnbull, MLA
Laid on the Table of the Legislative Assembly
on 21 September 1995

ORDERED TO BE PRINTED
"... giving birth is mostly a normal physiological event which does not require any form of medical intervention ... a natural phenomenon that only requires medical interference in pathological and rather exceptional situations.

... we cannot improve labour for a healthy woman. We can try to change the process, we can shorten it, we can speed it up, we can try to take away the pain, but at best we will do this without doing any harm. This leads to the conclusion, that the ideal obstetrical organization brings aid to women and children who need help (the pathological group) and protects the healthy ones against unnecessary interference and human meddlesomeness."

Professor GJ Kloosterman 1978

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SHARED CARE MODEL

Mandurah Birth Centre, 14 August 1995

[Photograph supplied by the Mandurah Mail]
On behalf of the Committee it gives me pleasure to present to the House the Report of the Select Committee on Intervention in Childbirth.

21 September 1995
Perth, Western Australia

DR H.M. TURNBULL, MLA (Chairman)

DR J.M. EDWARDS, MLA
(Deputy Chairman)

HON. I.F. TAYLOR, MLA

MRS J. VAN DE KLASHERST, MLA

MR J.L. BRADSHAW, MLA
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MEMBERS  Dr Judy Edwards, MLA *(Deputy Chairman)*
Mr John Bradshaw, MLA
Hon. Ian Taylor, MLA
Mrs June van de Klashorst, MLA

COMMITTEE STAFF

Clerk to the Committee  Ms Stefanie Dobro
Research Officer  Mrs Sue Laing
Secretary/Word Processing Officer  Mrs Pat Roach

COMMITTEE ADDRESS

Legislative Assembly Annexe Telephone :  (09) 222 7494
34 Parliament Place Facsimile :  (09) 321 9366
West Perth, WA  6005
CHAIRMAN'S REMARKS

In June last year, the Legislative Assembly set up a Select Committee of Inquiry to investigate the high rate of intervention in childbirth in Western Australia.

We have conducted what we believe has been a comprehensive examination of the available statistical data; evidence from witnesses representing mothers, consumer organisations, midwives, GPs and specialist obstetricians, as well as detailed studies of the maternity health care field in Western Australia.

From these we have concluded that -

! while the obstetrics' standards maintained in Western Australia are amongst the best in the world, the levels of intervention are high;

! experience overseas, nationally and in a number of instances in Western Australia, suggests that these high levels of intervention are unnecessary and reflect the predominance of the "clinical model" of maternity care.

Alternative models of maternity care that place greater reliance on "shared care" arrangements and "continuity of care", have enormous potential to reduce intervention levels without sacrificing maternal or infant safety standards which are among the best in the world.

The Committee believes the key to tapping this potential lies in fundamental changes of attitude on the part of all parties involved in maternity care.

The community in general, hospital personnel and the medical profession, all need to be reminded that pregnancy and birth should be completely normal healthy life events for the majority of women. Intervention should only occur where there are sound medical or physical reasons.

The Committee believes the best way to achieve changes in the attitudes of mothers is through education. Recommendations to this effect include -

! an information booklet on types of services provided by hospitals and birthing units along with names of midwives, GPs and specialist obstetricians;

! antenatal education services especially designed for mothers' individual needs;

! mothers having a copy of their own maternity records and writing their own "birth plan" if they wish.

Other recommendations call for organisational changes to shift the emphasis away from the "clinical model" of care and to focus on "continuity of care" and "shared care".

The lead professional in the shared care team should be the midwife, GP, or specialist, according to whether it is a low or high-risk labour. The Committee is of the opinion that specialist obstetricians are of greatest value as true consultants.
A survey of mothers in Western Australia revealed that mothers place great value in having a "companion in labour" and developing confidence in their midwives and doctors. These relationships help women to manage pain and fear during the delivery and are more important than the room and surroundings.

The management of pain and fear has an important role in achieving a normal vaginal birth without intervention.

Many witnesses agreed that the current levels of intervention in Western Australia are unnecessarily high. Consumer demand, attitudes within professional groups and the community, fear of litigation and the "cascade effect" of one intervention leading to another were cited as reasons.

Caesarean section rates are too high for mothers having their baby at over 35 years-of-age, for those who have had a previous caesarean section, where the baby is breech presentation and where the mothers are privately insured. The Committee recommends changes to allow more of these mothers safe vaginal births.

Concern has been expressed that the incidence of "postnatal depression" is increased in mothers who have had intervention during the birth of their child. The Committee views this seriously and recommends an increased focus on researching and developing strategies to prevent postnatal depression.

The Committee also examined the impact on the maternity health care area of the threat of litigation and has made a number of recommendations which it believes will go a long way to alleviating the problem.

Visits to regional and country hospitals revealed to us many of the reasons why the dedicated professionals providing the midwifery services have developed one of the safest services in the whole world.

During the life of the Committee we have been heartened to witness the development, after many years of negotiations, of "shared care" models at Swan District and Mandurah Hospitals. These have required radical changes to the organisation of work and responsibilities.

We trust that the recommendations of the Committee will be supported by the professional bodies of midwives, GPs and specialist obstetricians and will contribute to a fundamental change of attitude, which will focus on assisting mothers to achieve the great life event of giving birth with dignity, minimal intervention and safety.

DR HILDA TURNBULL, MLA
CHAIRMAN
TABLE OF CONTENTS

Chairman's Remarks v
Glossary of Terms xvi
Acronyms xix
Tables xx
Figures xxii
Acknowledgements xxiii
Establishment of the Select Committee and Terms of Reference xxiv
Reporting Date xxiv
Appointment of Committee Members xxv
Appointment of Committee Staff xxv
Committee Activities xxv
Submissions xxvii
Research xxvii
Budget Statement xxviii
Ministerial Direction xxx

1. INTRODUCTION 1

2. ATTITUDES AND EXPECTATIONS OF WOMEN AND THE COMMUNITY 3

2.1 Introduction 3
2.2 Community Surveys 3
   2.2.1 Consumer Views of Maternity Services: A Survey for Mothers 3
   2.2.2 A Report into Public Perceptions of Interventions during Childbirth 4
2.3 Attitudes and Expectations 5
   2.3.1 Expectation of Having a Normal Baby 5
   2.3.2 Consumer Demand 6
   2.3.3 Fear 8
   2.3.4 Satisfaction 8
   2.3.5 Choice 10
      Case notes 11
      Constraints on choice 12
   2.3.6 Continuity of Care 12
   2.3.7 Professional Care 13
   2.3.8 Knowledge 15
   2.3.9 Communication 15
Recommendations 17
3. STATISTICAL OVERVIEW OF CHILDBIRTH
IN WESTERN AUSTRALIA

3.1 Introduction

3.2 Statistical Collection in Western Australia
3.2.1 Midwives' Notification System
3.2.2 Hospital Morbidity Data System
3.2.3 Perinatal and Infant Mortality Database
3.2.4 Maternal Mortality Register
3.2.5 Maternal and Childhealth Database
3.2.6 Birth Defects Registry of Western Australia
3.2.7 Cerebral Palsy Register

3.3 Perinatal Statistics
3.3.1 Livebirths
3.3.2 Perinatal Mortality

3.4 Maternal Statistics
3.4.1 Maternal Mortality
3.4.2 Maternal Age
3.4.3 Maternal Parity
3.4.4 Maternal Race

3.5 Hospital Statistics
3.5.1 Number of Hospitals Which Have Maternity Patients

3.6 Place of Confinement
3.6.1 Planned Homebirths

3.7 Insurance Status
Recommendations

4. INTERVENTION IN PREGNANCY AND CHILDBIRTH

4.1 Introduction
4.1.1 Definition
4.1.2 Intervention Rates and Trends

4.2 Intervention
4.2.1 Ultrasound

Page No.

19
19
19
20
20
20
20
20
21
21
21
21
21
21
21
21
25
25
26
27
27
27
27
28
28
29
30
31
32
34
35
37
37
39
39
40
40
40
42
42
43
44
### 4. Cont'd

#### 4.2.2 Pain management
- Epidural analgesia
- Link between epidural analgesia and further intervention
- Continuous epidural analgesia vs intermittent epidural analgesia
- Patient controlled epidural analgesia (PCEA)
- Safety and side effects of epidurals
- Epidural services
- Hospital variation in epidural levels
- General anaesthesia
- Other anaesthesia/analgesia
- Non-drug techniques
- Education and informed consent

#### 4.2.3 Electronic Fetal Heart Rate Monitoring/Cardiotocography
- Statistics
- Negative aspects of EFM
- Positive aspects of EFM
- Policy guidelines and training
- Fetal scalp blood sampling
- Other forms of monitoring

#### 4.2.4 Induction
- Onset of labour
- Cervical ripening
- Augmentation of labour
- Amniotomy and oxytocin
- Active management of labour
- Use of prostaglandins
- Reasons for induction
- Post-term pregnancy
- Induction leading to other intervention

#### 4.2.5 Caesarean Section
- Reasons for caesarean sections
- Risks associated with caesarean sections
- Programs to lower caesarean section rates

#### 4.2.6 Assisted Vaginal Delivery
- Rates of assisted vaginal delivery
- Risks associated with forceps delivery and vacuum extraction

#### 4.2.7 Prevention of Postpartum Haemorrhage

#### 4.2.8 Episiotomy

#### 4.2.9 Beneficial Forms of Care and Forms of Care that Should be Abandoned

### 4.3 Suggested Ways to Reduce Intervention Rates

#### 4.3.1 Active Labour

#### 4.3.2 Community Education

#### 4.3.3 Consultation

#### 4.3.4 Labour Support
- Terminology

#### 4.3.5 Professional Education

#### 4.3.6 Audits

#### 4.3.7 Peer Review

#### 4.3.8 Quality Assurance

### 4.4 In Vitro Fertilization

Recommendations
5. MODELS OF CARE

5.2 Shared Care
5.2.1 Definition
5.2.2 Mandurah Birth Centre
5.2.3 Swan Health Services Antenatal Clinic and Birth Centre
5.2.4 Woodside Maternity Hospital
5.2.5 Denmark District Hospital
5.2.6 Kalgoorlie Regional Hospital
5.2.7 Private Sector

5.3 Birthing Centres
5.3.1 Family Birth Centre, King Edward Memorial Hospital for Women
5.3.2 Background
5.3.3 Statistics (1 July 1993 - 30 June 1994)
5.3.4 Policies and protocols
5.3.5 Continuity of care

5.4 Domino Birth

5.5 Homebirth
5.5.1 Statistics
5.5.2 Appropriate Care
5.5.3 Attitudes and Beliefs
5.5.4 Safety
5.5.5 Transfers

5.6 Hospital Care

5.7 Specialist Care
5.8 Continuity of Care
5.8.1 Examples of Alternative Work Arrangements
5.8.2 Staff Rotation
5.8.3 Personal Maternity Records (Case Notes)
5.8.4 Birth Plans

5.9 Postnatal Care
5.9.1 Hospital Care
5.9.2 Early Discharge Programs
5.9.3 Postnatal Domiciliary Care Programs
5.9.4 Postnatal Education
5.9.5 Debriefing

5.10 Funding
5.10.1 Alternative Birthing Services Program
5.10.2 Funded Western Australian Projects
5.10.3 Funding proposals

5.11 Conclusion

Recommendations
6. **POSTNATAL DEPRESSION**

6.1 Introduction 125
6.2 Incidence Following Intervention 126
6.3 Prevention and Treatment 126
6.4 Research Recommendations 127

7. **PROFESSIONAL ROLES**

7.1 Introduction 129
7.2 Role of the Midwife 130
7.2.1 Definition of a Midwife 130
7.2.2 Midwife Demographics 132
7.2.3 Areas in which Midwives Work 135
7.2.4 Midwife Registration and Accreditation 137
7.2.5 Remuneration and Refunds for Midwifery Services 139
7.3 Role of the General Practitioner 141
7.3.1 GP Demographics 142
7.3.2 Decline in the Number of GP Obstetricians 143
7.3.3 Incentives for GPs 145
7.3.4 Rural GP Obstetricians 147
7. Cont’d

7.4 Role of the Obstetrician
7.4.1 Specialist Demographics
  ! Age
  ! Gender
  ! Specialist distribution
  ! Sector of work
  ! Hours worked
7.4.2 Decline in the Number of Specialist Obstetricians
  ! Reasons for the decline in numbers of specialist obstetricians
  ! Country specialists
7.4.3 Specialist Remuneration
Recommendations

8. PROFESSIONAL EDUCATION AND TRAINING

8.1 Introduction
8.2 Training of Midwives
  8.2.1 International Differences in Training
  8.2.2 Midwifery Syllabus
  8.2.3 Hospital Training
  8.2.4 University Training
    ! Enrolment requirements
    ! Midwifery courses
  8.2.5 Midwifery Centre of Excellence
  8.2.6 Direct Entry Training
  8.2.7 Registration
  8.2.8 Continuing Education
8.3 Training of Medical Undergraduates
  8.3.1 Current Curriculum
  8.3.2 Country Training
  8.3.3 Midwifery Tutor Position
8.4 Training of General Practitioners
  8.4.1 Certificate of Satisfactory Completion of Training in Women’s
    Reproductive Health (CSCT)
  8.4.2 Diploma of the Royal Australian College of Obstetricians and Gynaecologists
    (DRACOG)
  8.4.3 Re-skilling
    ! Urban GP obstetrician re-skilling program
    ! Continuing medical education weekend
    ! Training in peripheral hospitals
  8.4.4 Training Curriculum in Obstetrics for Rural General Practice
  8.4.5 Training Costs
8.5 Training of Obstetricians
8.6 Training of Anaesthetists
Recommendations
9. RELATED RESEARCH IN WESTERN AUSTRALIA
  9.1 Introduction
  9.2 Current Research in Western Australia
    9.2.1 King Edward Memorial Hospital for Women
    9.2.2 Foundation for Women’s and Infants’ Health
    9.2.3 Institute for Child Health Research
    9.2.4 Edith Cowan University School of Nursing
  9.3 The Cochrane Collaboration
  Recommendations

10. MEDICO-LEGAL ISSUES
  10.1 Introduction
  10.2 Professional Indemnity
    10.2.1 Insurance by Employers
    10.2.2 Self Insurance
      ! Medical defence subscriptions
      ! Medical Defence Association of WA
    10.2.3 Professional Indemnity for Midwives
  10.3 Strategies Addressing Medico-Legal Issues
    10.3.1 No Fault Liability
    10.3.2 Statute of Limitations
    10.3.3 Capping of Claims
    10.3.4 Structured Settlements
    10.3.5 Other Strategies
  10.4 Obstetric Responsibility
  10.5 Informed Consent
  10.6 Conciliation Service
  Recommendations

11. EDUCATION PROGRAMS
  11.1 Introduction
  11.2 School-based Education
    11.2.1 Human Biology
    11.2.2 Health Education
    11.2.3 Home Economics
  11.3 Community Education
    11.3.1 Community Education Strategies
      ! Education sessions
      ! The Parents, Babies and Children’s Show
      ! International Day of the Midwife

Page No.
173
174
174
174
175
176
176
178
179
180
180
182
185
185
186
186
186
188
188
189
189
190
191
193
195
195
195
195
196
197
197
197
197
# Select Committee on Intervention in Childbirth

## 11. Cont’d

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.4 Preconceptual Education</td>
<td>198</td>
</tr>
<tr>
<td>11.5 Antenatal Education</td>
<td>198</td>
</tr>
<tr>
<td>11.5.1 Availability</td>
<td>199</td>
</tr>
<tr>
<td>! Preparation for parenthood</td>
<td>200</td>
</tr>
<tr>
<td>! Information about procedures in hospitals</td>
<td>200</td>
</tr>
<tr>
<td>11.5.2 Reasons for Not Attending Antenatal Classes</td>
<td>201</td>
</tr>
<tr>
<td>11.5.3 Suggestions for Improvements to Antenatal Education</td>
<td>201</td>
</tr>
<tr>
<td>11.6 Postnatal Education</td>
<td>202</td>
</tr>
<tr>
<td>! Debriefing</td>
<td>202</td>
</tr>
<tr>
<td>Recommendations</td>
<td>203</td>
</tr>
</tbody>
</table>

## 12. WOMEN AND GROUPS WITH SPECIAL NEEDS

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1 Introduction</td>
<td>205</td>
</tr>
<tr>
<td>12.2 Multicultural Women</td>
<td>205</td>
</tr>
<tr>
<td>12.2.1 Services Available to Multicultural Women</td>
<td>206</td>
</tr>
<tr>
<td>12.3 Aboriginal Women</td>
<td>207</td>
</tr>
<tr>
<td>12.3.1 Statistics</td>
<td>207</td>
</tr>
<tr>
<td>! Intervention rates</td>
<td>207</td>
</tr>
<tr>
<td>12.3.2 Committee’s Visit to Kalgoorlie</td>
<td>207</td>
</tr>
<tr>
<td>! Cultural Birthing Centre</td>
<td>207</td>
</tr>
<tr>
<td>12.3.3 Needs of Aboriginal Women</td>
<td>207</td>
</tr>
<tr>
<td>! Women’s needs</td>
<td>207</td>
</tr>
<tr>
<td>! Leaving the land</td>
<td>209</td>
</tr>
<tr>
<td>! Antenatal care and education</td>
<td>209</td>
</tr>
<tr>
<td>12.3.4 Education of Health Providers</td>
<td>210</td>
</tr>
<tr>
<td>12.3.5 Health Worker Training</td>
<td>210</td>
</tr>
<tr>
<td>12.4 Adolescent Women</td>
<td>211</td>
</tr>
<tr>
<td>12.4.1 Statistics</td>
<td>212</td>
</tr>
<tr>
<td>12.4.2 Adolescent Clinic Model</td>
<td>212</td>
</tr>
<tr>
<td>12.5 Older Women 213</td>
<td>213</td>
</tr>
<tr>
<td>12.5.1 Statistics</td>
<td>213</td>
</tr>
<tr>
<td>12.6 Women with Disabilities</td>
<td>214</td>
</tr>
<tr>
<td>12.7 Women with a Chemical Dependency</td>
<td>214</td>
</tr>
<tr>
<td>Recommendations</td>
<td>215</td>
</tr>
</tbody>
</table>

## 13. ECONOMICS OF CHILDBIRTH

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1 Introduction</td>
<td>217</td>
</tr>
<tr>
<td>13.2 Obstetric Costs</td>
<td>217</td>
</tr>
<tr>
<td>13.2.1 Delivery Costs</td>
<td>217</td>
</tr>
<tr>
<td>13.2.2 Bed Day Costs</td>
<td>217</td>
</tr>
<tr>
<td>13.3 Medicare Rebates</td>
<td>219</td>
</tr>
<tr>
<td>13.4 Remuneration for Health Professionals</td>
<td>220</td>
</tr>
<tr>
<td>13.4.1 Remuneration for GPs</td>
<td>221</td>
</tr>
<tr>
<td>13.4.2 Remuneration for Obstetricians as Consultants</td>
<td>221</td>
</tr>
<tr>
<td>13.4.3 Remuneration for Midwives</td>
<td>222</td>
</tr>
<tr>
<td>13.5 Suggested use of Maternity Service Funding</td>
<td>223</td>
</tr>
<tr>
<td>Recommendations</td>
<td>224</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY 225
WITNESSES WHO APPEARED BEFORE THE COMMITTEE 237
SUBMISSIONS RECEIVED BY THE COMMITTEE 241
APPENDICES 245

APPENDICES -

Appendix A Investigative Tours
Appendix B Consumer Views of Maternity Services: A Survey for Mothers
Appendix C Data from the Western Australian Pregnancy Cohort (Raine) Study
Appendix D A Guide to Effective Care in Pregnancy and Childbirth : A synopsis
Appendix E Guidelines for exclusion and transfer, Family Birth Centre
Appendix F Essential midwifery intervention skills
### GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antenatal care</strong></td>
<td>Care of women during pregnancy by doctors and midwives in order to predict and detect problems with the mother or the unborn child. Advice is also offered on other matters relevant to pregnancy and birth.</td>
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<tr>
<td><strong>Antenatal clinic</strong></td>
<td>A clinic often in a hospital where care is provided by midwives, GPs, obstetricians and other health professionals.</td>
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<td><strong>Birth centre</strong></td>
<td>A homelike environment where a woman can give birth within or close to a maternity unit and receive intrapartum and postnatal care from midwives and doctors or midwives only.</td>
</tr>
<tr>
<td><strong>Birth plan</strong></td>
<td>A written record of a woman's preferences for her care and that of her unborn child during labour and childbirth.</td>
</tr>
<tr>
<td><strong>Cardiotocography</strong></td>
<td>A graphical record of the fetal heart rate and uterine contractions.</td>
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<tr>
<td><strong>Care giver</strong></td>
<td>A health professional providing services for a client or patient.</td>
</tr>
<tr>
<td><strong>Confinement</strong></td>
<td>A pregnancy resulting in at least one birth.</td>
</tr>
<tr>
<td><strong>Consumer</strong></td>
<td>A user of maternity services; the pregnant woman.</td>
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<td><strong>Early discharge</strong></td>
<td>Discharge from a maternity unit or birth centre within a few hours or up to five days after giving birth.</td>
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<tr>
<td><strong>Elective caesarean</strong></td>
<td>Operative birth through an abdominal incision performed section: before the onset of labour.</td>
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<tr>
<td><strong>Emergency caesarean section</strong></td>
<td>Operative birth through an abdominal incision performed after the onset of labour.</td>
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<tr>
<td><strong>Epidural (anaesthesia or analgesia)</strong></td>
<td>A local anaesthetic injected around the spinal sac causing some numbness in the lower part of the body. It relieves labour pains effectively.</td>
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<tr>
<td><strong>Fetus</strong></td>
<td>The unborn child.</td>
</tr>
<tr>
<td><strong>Fetal</strong></td>
<td>Of fetus.</td>
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<tr>
<td><strong>GP obstetrician</strong></td>
<td>A general practitioner registered to practice medicine by a State or Territory, usually with the Diploma of the Royal Australian College of Obstetricians and Gynaecologists, who provides maternity care. Part or all of antenatal, intrapartum and postnatal care may be provided by the general practitioner.</td>
</tr>
</tbody>
</table>
**Glossary of Terms cont'd**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk pregnancy:</td>
<td>A pregnancy in which a risk of complication is evident or in which a complication occurs.</td>
</tr>
<tr>
<td>Independent midwife:</td>
<td>A midwife who practises independently and who may be accredited to the Australian College of Midwives Inc.</td>
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<tr>
<td>Intervention:</td>
<td>Clinical procedure in pregnancy or labour, e.g. induction of labour, delivery of the fetus with forceps or by caesarean section.</td>
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<td>Intrapartum:</td>
<td>During labour.</td>
</tr>
<tr>
<td>Labour ward:</td>
<td>A suite of rooms set aside in a maternity unit for care of women in labour.</td>
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<tr>
<td>Maternal age:</td>
<td>Mother's age at her child's birth.</td>
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<tr>
<td>Maternity unit:</td>
<td>A building or group of buildings in which maternity care is provided. It can be located within or adjacent to a general hospital, or away from other hospital services.</td>
</tr>
<tr>
<td>Midwife:</td>
<td>A person registered by a State or Territory to practice midwifery.</td>
</tr>
<tr>
<td>Midwife in private practice:</td>
<td>See &quot;independent midwife&quot;.</td>
</tr>
<tr>
<td>Multiparous:</td>
<td>Having borne at least one child previously.</td>
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<tr>
<td>Neonatal:</td>
<td>Refers to the first 28 days after birth.</td>
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<tr>
<td>Nulliparous:</td>
<td>Having never borne a child previously</td>
</tr>
<tr>
<td>Perinatal:</td>
<td>Refers to the period from 20 weeks of pregnancy to 28 days after birth.</td>
</tr>
<tr>
<td>Postnatal:</td>
<td>Pertaining to the few weeks after birth.</td>
</tr>
<tr>
<td>Primipara:</td>
<td>A woman bearing a child for the first time.</td>
</tr>
<tr>
<td>Private patient:</td>
<td>A person who elects to be responsible for fees charged by the hospital and care givers.</td>
</tr>
<tr>
<td>Public patient:</td>
<td>A person who elects to receive care as defined by the Medicare agreements.</td>
</tr>
<tr>
<td>Puerperium:</td>
<td>The six weeks immediately after childbirth.</td>
</tr>
</tbody>
</table>
Glossary of Terms cont’d

Specialist obstetrician: A doctor who has the Fellowship of the Royal Australian College of Obstetricians and Gynaecologists and is registered as a specialist obstetrician by a State or Territory.

Stillbirth: The complete expulsion or extraction from its mother of a product of conception of at least 20 weeks gestation or 400 grams birthweight, which after separation did not show any sign of life.

Team midwifery: A small group of midwives who provide care for their clients. The woman receives care in labour from a midwife known to her.
**ACRONYMS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ABC</td>
<td>Alternative Birthing Centre</td>
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<td>GIFT</td>
<td>Gamete Intrafallopian Transfer</td>
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<tr>
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<td>Medical Defence Union</td>
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<tr>
<td>MIPP</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NTP</td>
<td>Ngunytju Tjitji Pirni</td>
</tr>
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<tr>
<td>PCEA</td>
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</tr>
<tr>
<td>PDCP</td>
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</tr>
<tr>
<td>PIR</td>
<td>Professional Indemnity Review</td>
</tr>
<tr>
<td>PPH</td>
<td>Postpartum Haemorrhage</td>
</tr>
<tr>
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<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>---------</td>
<td>------------------------------------------------------</td>
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<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
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<td>RDA</td>
<td>Rural Doctors Association</td>
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<tr>
<td>RTU</td>
<td>Rural Training Unit</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<tr>
<td>TENS</td>
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<td>VBAC</td>
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</tr>
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</tr>
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<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WACRRM</td>
<td>Western Australian Centre for Remote and Rural Medicine</td>
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## TABLES

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<tr>
<th>Table No.</th>
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<tr>
<td>1.</td>
<td>Perinatal Mortality Rate by State or Territory of usual Residence of Mother, 1993.</td>
<td>22</td>
</tr>
<tr>
<td>2.</td>
<td>Stillbirths, Neonatal and Perinatal Mortality Rates by Maternal Race in Western Australia, 1993.</td>
<td>23</td>
</tr>
<tr>
<td>3.</td>
<td>Parity and Age of Women Confined in Western Australia, 1993.</td>
<td>27</td>
</tr>
<tr>
<td>4.</td>
<td>Maternity Bed-Days for Hospitals in Western Australia, 1993.</td>
<td>28</td>
</tr>
<tr>
<td>5.</td>
<td>Average Length of Stay (Days) in Hospital following Birth Event for all Women Confined, 1989-1993.</td>
<td>29</td>
</tr>
<tr>
<td>6.</td>
<td>Obstetrics Procedures within the 100 most frequent Operations/Procedures performed in Western Australia, 1993/94.</td>
<td>29</td>
</tr>
<tr>
<td>7.</td>
<td>Place of Confinement in Western Australia, 1993.</td>
<td>31</td>
</tr>
<tr>
<td>8.</td>
<td>Number and Percentage of Homebirths, States and Territories, 1991.</td>
<td>32</td>
</tr>
<tr>
<td>9.</td>
<td>Proportion of Population with Basic and Supplementary Hospital Insurance, Western Australia, 1983 and 1993.</td>
<td>32</td>
</tr>
<tr>
<td>10.</td>
<td>Type of Delivery, Women Confined in Western Australia, 1993.</td>
<td>37</td>
</tr>
<tr>
<td>11.</td>
<td>Births to women resident in the Perth Metropolitan area, hospital and type of delivery, 1993.</td>
<td>38</td>
</tr>
<tr>
<td>12.</td>
<td>Caesarean Section, Instrumental Vaginal Delivery and Total Operative Rates.</td>
<td>39</td>
</tr>
<tr>
<td>13.</td>
<td>Anaesthesia/Analgesia and Type of Delivery for Women Confined in Western Australia, 1993.</td>
<td>45</td>
</tr>
<tr>
<td>14.</td>
<td>Onset of Labour, All Confinements, States and Territories.</td>
<td>58</td>
</tr>
<tr>
<td>15.</td>
<td>Onset and Augmentation of Labour and Type of Delivery for Women Confined in Western Australia, 1993.</td>
<td>59</td>
</tr>
<tr>
<td>16.</td>
<td>Type of Delivery and Parity of Women Confined in Western Australia, 1993.</td>
<td>63</td>
</tr>
<tr>
<td>17.</td>
<td>Rates of Caesarean Section, States and Territories.</td>
<td>64</td>
</tr>
<tr>
<td>18.</td>
<td>Place of Confinement and Caesarean Section for Women Confined in Western Australia, 1993.</td>
<td>65</td>
</tr>
<tr>
<td>19.</td>
<td>Complications of Labour and Delivery for Women Confined by Caesarean Section in Western Australia, 1993.</td>
<td>67</td>
</tr>
</tbody>
</table>
Table No. | Description | Page No.
--- | --- | ---
21. | Rates of Caesarean Section by Insurance Status in Three Populations of Western Australian Women, 1990-1993. | 71
22. | Type of Delivery and Patient Insurance Status in KEMH. | 72
23. | Primiparous Women with Singleton Pregnancy, Insurance Status, Maternal Age and Type of Delivery, 1990-1993. | 73
24. | Rates of Operative Vaginal Delivery, States and Territories. | 78
25. | Type of Delivery and Plurality of IVF/GIFT Confinements. | 86
28. | Characteristics of the WA Nursing Labourforce Registered as Midwives. Number and Percentage of Clinician Midwives in Each Age Group Employed in Specific Areas of Practice. | 134
29. | Number of Practising Providers (GP Obstetricians) in Metropolitan WA and Country WA, By Year. | 135
30. | RACOG Statistics, Western Australia, 1994. | 143
31. | Number of Practising Providers (Specialist Obstetricians) in Metropolitan WA and Country WA, By Year. | 150
33. | Medicare Benefits, 1994. | 218
34. |  | 219

**FIGURES**

3. Operative Deliveries, Western Australia, 1984-1993. | 38
4. Postulated Chain of Diagnostic and Therapeutic Intervention in Perinatal Services. | 41
5. Caesarean Sections, Western Australia, 1984-1993. | 64
6. Swan Health Service, Maternity Models of Care. | 97
7. Family Birth Centre (FBC), Transfers and Deliveries, (1/7/93 - 30/6/94) | 101
8. Medical Defence Union Subscription Rates (SA) | 183
ACKNOWLEDGEMENTS

The Select Committee on Intervention in Childbirth expresses its thanks to the many individuals and organisations who sent in submissions and/or provided oral evidence to the Committee during its investigations. The evidence received by the Committee came from a wide range of individuals and organisations including mothers, midwives, medical staff and professionals, professional organisations and consumer groups all of whom contributed to the enhancement of knowledge of the members of the Committee on matters related to intervention in childbirth.

The Committee expresses its thanks to the women of Western Australia who have shared their experiences and those who responded to the *Survey for Mothers*.

The Committee thanks Professor Con Michael who was Chairman of the 1989 WA Ministerial Task Force for his support and input during the Committee's investigations.

The Committee thanks Ms Sue van Leeuwen, Ms Noaleen Crosbie, Dr Keith Howe, Ms Anita Fratel and Ms Anna Maides for their help in organising the Committee's investigative tour to the South West. Similarly, the Committee expresses its appreciation to Mrs Jacqui Garrard for coordinating the Committee's schedule for its visit to Kalgoorlie as well as to all of those who participated in the Committee's investigative process during these visits.

The Committee would also like to thank the staff of the Health Statistics Branch of the Health Department of Western Australia for all their help in providing data as well as in organising and conducting the *Survey for Mothers* on behalf of the Committee. In particular, the Committee would like to thank Mrs Vivien Gee, Dr Ian Rouse, Dr James Semmens and Dr Marisa Gilles.

The Committee wishes to acknowledge the assistance of Dr Sharon Evans at the Foundation for Women's and Infants' Health who compiled data from the Western Australian Pregnancy Cohort (Raine) Study and Clinical Professor John Newnham for his assistance in providing background information.

The Committee thanks Health Promotion Services of the Health Department of Western Australia for providing editorial and artistic design assistance.

The Committee also expresses its thanks to the Clerk, the Deputy Clerk, and the Clerk Assistant for the support they have provided to the Committee. The Committee expresses its appreciation to the Clerk to the Committee, Ms Stefanie Dobro, and to Mr Michael Baker who was Acting Clerk to the Committee, and to *Hansard* for its help in efficiently providing accurate transcripts of evidence. Special thanks are extended to Mrs Patricia Roach for her wordprocessing expertise in preparing the Report.

Finally, special acknowledgment must be made of the effort and commitment by the Research Officer, Mrs Sue Laing, who worked on a part-time to increasingly full-time basis for a period of ten months. With her vast knowledge of the subject matter, her research and report writing skills and her keen interest and dedication to the project, Mrs Laing's involvement proved to be of inestimable value. The Committee also thanks Mrs Laing for her contributions to the advancement of the Committee's investigations through her actions in her personal capacity. The Committee also expresses its thanks to the Health Department of Western Australia for providing Mrs Laing to the Committee on secondment.
1. ESTABLISHMENT AND MEMBERSHIP OF THE COMMITTEE AND THE TERMS OF REFERENCE

On 16 June 1994 Dr Hilda Turnbull moved the following -

That a Select Committee be appointed to investigate and report on all aspects of the high rate of intervention in childbirth in Western Australia, and in particular -

(a) assess the impact of expectations and demands by mothers and the community in generating increased intervention in childbirth;

(b) assess the impact of medico-legal demands in increasing the intervention in childbirth and the effect on mothers, families, personnel and facilities involved in the childbirth process;

(c) assess the expectation and outcomes of the activities of general practitioners, specialists, midwives and other persons associated with the mother and child during the child birth;

(d) assess the impact of technology on the rate of intervention, and the outcomes;

(e) assess the intervention rate and outcomes in IVF pregnancies;

(f) investigate the outcomes of all obstetric cases to ascertain the degree of intervention and the location of delivery whether at home, or hospital, in the country, in the metropolitan area or in a tertiary hospital, either public or private;

(g) assess the potential for and the effective limits of minimal intervention for low-risk patients in programs, such as "Birthing Suites", "Independent Midwives", "Home Births", in country or metropolitan areas;

(h) ascertain the current curricula of training in obstetric management by institutions responsible for undergraduate or postgraduate training of doctors, nurses and midwives;

(i) report on whether in some circumstances public funds spent on intervention could be spent more effectively in programs which encourage minimal intervention; and

(j) assess any other matters related to childbirth which affect the outcomes for the baby or mother.

2. REPORTING DATE

The original motion on 16 June 1994 set the date for presentation of the Committee's report as 31 May 1995. This date was subsequently extended to 28 June 1995 by the House on 4 May 1995. This reporting date was changed again on 20 June 1995 and extended to 7 September 1995. The reporting date was further extended on 30 August 1995 to 21 September 1995.
3. **APPOINTMENT OF COMMITTEE MEMBERS**

On motion by Dr Turnbull on Thursday, 16 June 1994, it was resolved -

That the following Members be appointed to the Committee -

- the Member for Wellington (Mr J.L. Bradshaw, MLA)
- the Member for Maylands (Dr J.M. Edwards, MLA)
- the Member for Victoria Park (Dr G.I. Gallop, MLA)
- the Member for Collie (Dr H. Turnbull, MLA)
- the Member for Swan Hills (Mrs J. van de Klashorst, MLA)

Dr Hilda Turnbull was elected Chairman of the Committee on Tuesday, 21 June 1994. Dr Judy Edwards was elected Deputy. Dr Turnbull and Dr Edwards were re-elected to the respective positions of Chairman and Deputy on Tuesday, 4 April 1995.

On motion by Hon. C.J. Barnett (Leader of the House) on Thursday, 8 December 1994 it was resolved -

That the Member for Victoria Park be discharged from the Select Committee on Intervention in Childbirth and the Member for Kalgoorlie (Hon. I.F. Taylor, MLA) be appointed in his place.

4. **APPOINTMENT OF COMMITTEE STAFF**

The Clerk of the Legislative Assembly appointed Mr Michael Baker, Senior Research Officer, as Acting Clerk to the Committee. Ms Stefanie Dobro, Parliamentary Officer, was subsequently appointed as Clerk to the Committee.

Mrs Sue Laing was seconded from the Health Department of Western Australia, following approval of the Speaker of the Legislative Assembly, to act as Research Officer to the Committee.

5. **COMMITTEE ACTIVITIES**

Meetings Dates

The Select Committee met on the following occasions -

- Tuesday, 21 June 1994
- Tuesday, 26 July 1994
- *Monday, 8 August 1994
- Wednesday, 14 September 1994
- *Thursday, 13 October 1994
- *Monday, 7 November 1994
- Wednesday, 16 November 1994
- *Thursday, 1 December 1994
- Thursday, 8 December 1994
- *Wednesday, 8 February 1995
- *Thursday, 9 February 1995
- *Thursday, 16 February 1995
- Wednesday - Friday, 22-24
February 1995 (Investigative Tour to Collie, Bunbury and Pinjarra)  
Tuesday - Wednesday, 7-8 March 1995  
(Investigative Tour to Kalgoorlie)  
*Wednesday, 29 March 1995  
Tuesday, 4 April 1995  
*Wednesday, 5 April 1995 (Visit to Swan District Hospital)  
*Wednesday, 12 April 1995  
*Wednesday, 26 April 1995  
*Thursday, 27 April 1995  
*Wednesday, 10 May 1995  
Friday, 26 May 1995 (Visit to St John of God Hospital, Murdoch and Woodside Maternity Hospital)  
Wednesday, 14 June, 1995  
*Tuesday, 18 July, 1995  
Wednesday, 16 August 1995  
Tuesday, 22 August 1995  
Wednesday, 23 August 1995  
Wednesday, 30 August 1995  

(*Indicates days on which evidence was taken.)  

Informal meetings were also held.  

Oral evidence was taken at several of these meetings. The Committee acknowledges the assistance of *Hansard* reporting staff and typists in providing transcripts of evidence.  

**Investigative Tours**  

The Committee visited a number of country centres and met with medical practitioners, hospital and Health Department staff, representatives from community groups and members of the public.  

(1) **Tour of Collie, Bunbury and Pinjarra, 22-24 February 1995**  
The Committee visited Collie District Hospital, South Bunbury Community Health Centre (public meeting), Milligan House, Bunbury (meeting with the South West Homebirth Support Group), Bunbury Regional Hospital, Pinjarra (Murray) District Hospital and held a meeting with doctors from the Bunbury area.  

(2) **Tour of Kalgoorlie, 7-8 March 1995**  
The Committee visited Kalgoorlie Regional Hospital and met with hospital administrators and midwives, an obstetrician and gynaecologist, local doctors, community nursing staff, representatives from the Royal Flying Doctor Service, the Bega Gambirringu Health Service, the Health Department's Aboriginal Policy and Planning Branch, and the Ngunytjju Tjitji Piri Program. The Committee also invited members of the community to attend a public meeting.
(3) Mandurah Birth Centre, 14 August 1995

The Chairman attended the opening of the Mandurah Birth Centre, met with staff and discovered how the centre was being run.

(4) Visit to Oxford and Cambridge, England

On behalf of the Committee, the Hon. Ian Taylor visited the Rosie Maternity Hospital in Cambridge. He also met with Professor Iain Chalmers to discuss the Cochrane Pregnancy and Childbirth Database.

(5) Visit to Amsterdam, the Netherlands, 25 July 1995

On behalf of the Committee, Mrs June van de Klashorst met with Professor Dr P. Treffers, an obstetrician and gynaecologist; and Ms Beatrijs Smulders, a Dutch midwife, to discuss obstetrics and midwifery in the Netherlands.

The reports on the investigative tours can be found in Appendix A.

The Committee also visited the following hospitals within the metropolitan area -

Family Birth Centre, King Edward Memorial Hospital for Women;
Swan District Hospital;
St John of God Hospital, Murdoch;
Woodside Maternity Hospital.

The reports on the hospital visits are also included in Appendix A. A formal hearing was held at Swan District Hospital, therefore the report on that visit is short.

6. SUBMISSIONS

The Committee wishes to thank all the people who responded to the call for public submissions. Submissions numbered 81. A list of submissions is provided at the end of the report.

7. RESEARCH

The Committee commissioned Dr Sharon Evans, Biostatistician at the Foundation for Women's and Infants' Health, King Edward Memorial Hospital for Women to prepare some statistics from the Western Australian Pregnancy Cohort (Raine) Study.

In addition, the Committee asked the Health Department of Western Australia to conduct a survey of women who had recently given birth to find out about their views of maternity services in the State.
8. BUDGET STATEMENT

Note: Committee established 16 June 1994.

Travel Expenses

Collie, Bunbury and Pinjarra (22-24 February 1995) #1

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<tr>
<th>Item</th>
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<td></td>
<td>Staff</td>
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Incidental expenses 100 $1,700

Kalgoorlie (7-8 March 1995) #2

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<td></td>
<td>Staff</td>
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Airfares Members 700 Staff 700 Incidental expenses 200 $2,700

General Expenses

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<td>Refreshments</td>
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<tr>
<td>Stationery and photocopying</td>
<td>750</td>
</tr>
<tr>
<td>Taxis</td>
<td>250</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$47,900</strong></td>
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</table>

#1. Travel to Collie District Hospital, South Bunbury Community Health Centre (public meeting), Milligan House, South West Homebirth Support Group, Bunbury Regional Hospital and Pinjarra (Murray) District Hospital to meet with various health professionals and members of the community in relation to rates of intervention in childbirth and childbirthing experiences, undertaken by three members, Clerk and Research Officer.

#2. Travel to Kalgoorlie Regional Hospital to meet with hospital administrators and midwives, an obstetrician and gynaecologist, local doctors, community nursing staff, representatives from the Royal Flying Doctor Service, the Bega Garnbirringu Health Service, the Health Department's Aboriginal Policy and Planning Branch, and the Ngunytju Tjitji Pirni Program, and to meet with various members of the local community in relation to rates of intervention in childbirth and childbirthing experiences, undertaken by three members, Clerk and Research Officer.
#3. Mrs Sue Laing, Research Officer, seconded from the Health Department of Western Australia, Level 5 Year 1, starting 1 January 1995, $24,900 (adjusted according to part-time hours worked - 2.5 days per week from 01/01/95 to 20/02/95; 3.5 days per week from 21/02/95 to 23/04/95; and 4 days per week from 24/04/95 to 15/09/95). Dr Sharon Evans, Biostatistician, consulted regarding analysis of Western Australian Pregnancy Cohort (Raine) Study findings, $1,000.
MINISTERIAL DIRECTION

In accordance with Standing Order 378(c) the Committee directs that the Minister for Health be required, within not more than three months, or at the earliest opportunity after that time if Parliament is in adjournment or recess, to report to the House as to the action, if any, proposed to be taken by the Government with respect to the recommendations of this report.
CHAPTER ONE

INTRODUCTION

The report of the Select Committee on Intervention in Childbirth has been written in response to concerns that the levels of intervention in childbirth in Western Australia are too high.

While the report is not brief, it has not attempted to cover every aspect on intervention in childbirth. It has tried to highlight the opinions and information provided by the many witnesses who gave oral evidence and the individuals and organisations who provided written submissions. The report contains many recommendations based on the Committee's findings and in addition, the Committee hopes that it will be used as a means of raising awareness and discussion about maternity services in the State.

In Chapter Two, the report examines the attitudes and expectations of mothers in Western Australia because they are, and should be generally regarded as the central focus of maternity services in this State.

The report then proceeds to examine statistics for Western Australia including mortality, morbidity, place of confinement, and levels of intervention. Particular interventions have been examined closely and findings from scientific literature have been quoted.

The Committee examined some of the different models of maternity care which are being practised in Western Australia. In Chapter Five, the report discusses a number of these models such as shared care, birth centres, and homebirth.

Chapter Six examines postnatal depression and discusses the incidence of and the possible reasons for the condition.

The roles of midwives, general practitioners and specialist obstetricians are discussed in Chapter Seven. Information contained in the chapter includes demographics about the various groups, reasons for the decline in their numbers and suggests possible strategies to encourage professionals to continue in or to return to the practice of obstetrics.

Chapter Eight examines education and training programs available for health professionals in the area of obstetrics.

The Committee heard from various witnesses about the value of research in the area of intervention in childbirth. Chapter Nine reports on some current research being conducted in Western Australia and comments on the importance of continued research and tools that can be used to help professionals and interested others to find out more about effective obstetric practices.

The medico-legal aspects of intervention in childbirth are highlighted in Chapter Ten. The Committee has made some recommendations based on its findings but it is conscious that the forthcoming Commonwealth Department of Human Services and Health's Review of Professional Indemnity Arrangements for Health Care Professionals - Compensation and Professional Indemnity in Health Care will cover the issues in much greater depth.

Chapter Eleven looks at current education programs in Western Australia and addresses school
based, community, preconceptual, antenatal, and postnatal education.

Some groups in Western Australia appear to have special needs in the area of maternity care. Chapter Twelve examines some of the needs of these groups which include multicultural women, Aboriginal women, adolescent women, older women, women with disabilities and women with a chemical dependency.

The final chapter looks at the cost of obstetric procedures in the State and examines remuneration for health professionals. It also includes suggestions received by the Committee for alternative uses of funding for maternity services.

Recommendations are included throughout the text and are listed again at the end of each chapter. The Committee found that a number of areas under investigation overlapped. Therefore, throughout the report there are references to other parts of the document. In addition, quotes, text and recommendations have been repeated in different chapters if they are relevant.
CHAPTER TWO

ATTITUDES AND EXPECTATIONS OF WOMEN AND THE COMMUNITY

2.1 INTRODUCTION

The women of Western Australia and their families are at the centre of maternity services in this State. The views of women who have experienced pregnancy and childbirth and also those of members of the community, are fundamental to the assessment and future development of services in Western Australia. A number of submissions were received which addressed individuals' and community attitudes and expectations.

There is a strong opinion that community expectations about what to expect during childbirth were contributing factors to increasing intervention ... By comparison midwives view childbirth in healthy women as an essentially natural event requiring minimal intervention. The concept of women being in control of the process in active partnership with those assisting, needs to be introduced into people's belief systems at an early age.²

2.2 COMMUNITY SURVEYS

2.2.1 Consumer Views of Maternity Services: A Survey for Mothers.

In August 1989, as part of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia,³ chaired by Professor Con Michael, the Health Department of Western Australia conducted a consumer survey of maternity services in Western Australia. The survey looked at aspects of antenatal care, birth of the baby, postnatal care, infant feeding, community care, ethnic groups, low income groups and religion. The Committee decided it would be valuable to reassess the views of Western Australian women in 1995 to determine what changes, if any, had occurred in six years, in light of the fact that significant changes have occurred in the provision of obstetric care. These included a move away from private insurance, concerns about litigation by doctors, increasing intervention rates and the establishment of birthing units at some hospitals.⁴

In April 1995, the Health Department of Western Australia sent out a self-administered questionnaire to 961 women who had given birth to a liveborn child in Western Australia during November and December 1994. The questionnaire aimed to find out women's opinions about their care during pregnancy and childbirth, which procedures they had and the reasons for having them. The response rate to the questionnaire was 52% of those who had been contacted (n = 468).

² Submission 41 - Mrs Sue Terry.
The results of the consumer survey, henceforth referred to as the *Survey for Mothers*\(^5\) indicated a generally positive attitude towards the care women received during their pregnancy and confinement. However, a number of issues were raised which suggest that improvements can be made in the care of Western Australian mothers.

The questionnaire and report of the findings from the survey can be found in Appendix B.

### 2.2.2 A Report into Public Perceptions of Interventions During Childbirth.

The Committee heard evidence from Dr Keith Woollard, President of the Australian Medical Association (WA Branch) (AMA[WA]) and Dr Katrina Alexander, Chairman of the AMA(WA) Women's Health Issues Committee (9.2.95). They outlined a research survey conducted by Reark Research on behalf of the AMA(WA).\(^6\) Four hundred and eighty randomly selected households in the metropolitan area were contacted by telephone to survey community expectations. The main findings from the survey which Dr Woollard discussed were -

- some sixty per cent of respondents who had experienced, or witnessed childbirth indicated that some form of intervention had been used during the last childbirth...
- only 5% were not satisfied with the interventions given;
- ninety six per cent of respondents agreed that it was the patient's right to request intervention;
- ninety seven per cent of all respondents agreed that interventions should be applied if there was a perceived risk to the unborn child;
- eighty seven per cent of all respondents agreed that pregnancy and childbirth should be overseen by a GP and/or obstetrician;
- eighty one per cent of all respondents agreed that it was safer if a child was delivered in a hospital.

Dr Woollard (9.2.95) told the Committee that he felt that the survey indicated that -

> there is not a great ground swell of community concern about the level of intervention

and he said -

> we do not believe there was a great amount of community concern about the fact that the birthing process has shifted into the hospitals.

The Committee noted the AMA(WA)'s findings and has included the full survey with results in the tabled papers. However, the Committee felt that the survey was biased and contained a number of emotive and leading questions. The survey did not ask respondents to express their views on midwifery care and it directed the respondent with the following preamble -

> as you are probably aware, there are interventions that may be applied by doctors and obstetricians during childbirth. These interventions are primarily applied for pain relief or safety reasons where there is a perceived risk to mother and/or child.

### 2.3 ATTITUDES AND EXPECTATIONS

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\(^5\) *ibid.*

2.3.1 Expectation of Having a Normal Baby

Today's society has been led to believe that medical science can produce miracles and that parents can expect perfect results from pregnancy and childbirth. "Parents expect a perfect child each time. This is especially so now when the average family size is much less than in the past."7

Expenditure from the public purse on medicine is second only to defence in the national budget. The public naturally want[s] its money's worth and perfect results from pregnancy and childbirth is a high priority.8

Dr Katrina Alexander (9.2.95) told the Committee that -

low mortality rates have given people an expectation of a normal baby after a normal delivery with no intervention ... Australia is a very safe place to have a baby under our current system.

Dr Alexander also said that "women will take no risk for their baby" so this raises the dilemma about the use of intervention in case there might be a problem.

Over-reliance on "experts" leads women to expect perfection in the childbearing experience and when nature and the "expert" do not deliver this perfection, disillusionment can be the trigger for litigation.9

In 1985, the National Health and Medical Research Council Working Party investigated variations in caesarean section rates in Australia10 and expressed the belief that -

the inappropriate expectations of parents may increase pressures on obstetricians for intervention and rapid delivery. Improved education for parents and prospective parents should be encouraged, with particular attention to the following areas -

(a) the nature of normal labour;
(b) management of complications;
(c) indications for repeat caesarean section.11

The Committee heard from Professor Fiona Stanley (8.2.95) that "parents are unrealistic about what biology can deliver". In 1993, 4% of babies born in Western Australia were reported to

7 Submission 50 - Ms Anne-Marie Widermanski, Ms Pamela Robinson, Ms Lyn McArthur, Ms Joy Wilcock and Ms Christine Walsh, Glengarry Hospital.
8 Submission 10 - Dr Ralph Hickling, Obstetrician and Gynaecologist.
9 Submission 11 - Ms C Cook, Ms E Facer, Ms H Kay and Ms R Murphy, The Midwifery and Natural Childbirth Centre.
11 ibid., p 2.
have a birth defect (cerebral palsy results are not included).\textsuperscript{12} Figures from the Western Australian Cerebral Palsy Register indicate that the overall rate of cerebral palsy in 1988 was 2-2.5 per 1000 livebirths.\textsuperscript{13}

Professor Stanley said -

that is a fact of life - whatever we do that will happen - and 0.25% of children will develop cerebral palsy; 0.85% will develop intellectual disability - and so it goes on. We can give these expectations to people as the biological disability and mortality rates of this community, are pretty much standard around the world. It is very important that parents get this information ... It is the mother's and father's right to know the risks.

Professor Stanley also told the Committee about the risks associated with in vitro fertilisation.

They [parents] need to know when they are contemplating IVF what the risks are from having these procedures ... So people going into an IVF program know that the rate of multiple births will be this much; that the preterm pregnancy rate, irrespective of multiple births, will be 20%; that they will have a higher rate of mortality in their offspring.

It is suggested that public education is required as to realistic expectations and explanation of some undesirable outcomes for which obstetricians cannot be blamed. The appropriate use of technology and intervention also needs public debate.\textsuperscript{14}

\subsection{2.3.2 Consumer Demand}

The \textit{Survey for Mothers} asked respondents to provide the reasons for having intervention. It found that 10.5\% of women who indicated their reason for having an induction, said that they had made the request (the most common reason for having the birth induced was on the recommendation of the doctor),\textsuperscript{15} while 40.5\% of women who indicated their reason for having an epidural\textsuperscript{16} and 6.9\% of women who indicated why they had had a caesarean section,\textsuperscript{17} said that they had requested one in pregnancy or during labour. Other reasons cited for having an epidural included "[it was] offered before labour" or "during labour". Other reasons for having a caesarean included "my doctor recommended one" and "it was an emergency".

The Committee also received submissions from women who requested intervention.

\begin{quote}
My obstetrician questioned my request as there was no medical reason for another caesarean section. I felt comfortable having another caesarean as I knew what to expect and I was apprehensive about having a vaginal delivery as there was every chance that forceps or vacuum would be used to deliver the baby [in order] to place little strain on the uterine scar and also an episiotomy would probably be necessary.
\end{quote}

\begin{thebibliography}{99}
\item[14] Submission 35 - Osborne Division of General Practice.
\item[16] \textit{ibid.} p 33.
\item[17] \textit{ibid.} p 16.
\end{thebibliography}
If I was going to suffer hours of labour pain and still have incisions made, I would rather have a caesarean.  

The Committee heard from a number of doctors and members of the community that patients request intervention during labour and childbirth.

Often medical practitioners are subjected to intense pressure by their patients who request and even demand certain interventions for personal reasons when they are not medically indicated, e.g. caesarean sections and induction of labour for "social" reasons, repeated ultrasounds during pregnancy to "look at the baby" and epidural anaesthesia before other pain relief options have been considered or tried.

Women appear to welcome intervention. They would be ultimately better served by being given some education on the long-term effects of intervention.

I have noted an increase in requests for elective caesarean sections from my patients ... Fear is often the reason for the request ... Most women can have these fears alleviated, however, there is a definite increase.

Dr Roly Bott (9.2.95) told the Committee "more and more pressure is coming from patients to induce them once they are at term".

Professor Con Michael (7.11.94) told the Committee that "there is no doubt that patient requests have been a big factor in repeat caesarean sections" and "people are often terrified by what childbirth will involve and think a caesarean section is an easy option. We must therefore discuss it with them."

The Committee did hear from women who felt their doctors should have intervened when they did not. The author of an anonymous submission told the Committee -

if my initial doctor had intervened I would not have ended up in the mess I did; and

don't let "modern" medical opinion or public opinion make women like me feel imperfect, worthless or a failure because we need intervention.

The Committee also heard from women and of women who wanted little or no intervention during pregnancy and childbirth.

There is an important minority who want no interference and sometimes seem to accept substantial risks in order to achieve natural childbirth in a setting of their own

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18 Submission 20 - Mrs Margo Campbell.
19 Submission 24 - Dr Donna Mak.
20 Submission 4 - Mrs Ethel Kempton.
21 Submission 3 - Dr Mark McKenna.
22 Submission 71 - Anonymous.
choice. They do better than obstetric tradition would have us believe, perhaps because they are highly motivated and generally healthy people.23

2.3.3 Fear

Fear associated with pregnancy and childbirth is a major issue for many women.

To reverse the ever-increasing fear that women today have about pregnancy and birth, tests should be kept to a minimum and newspapers should stop their numerous front page articles about the wonders of modern medicine in abnormal cases. It creates the impression that abnormal birth is the norm and it causes great fear among women.24

Dr Alexander (9.2.95) told the Committee that -

very few women want to do without pain relief. One of the main fears ... is ... having pain, losing control and being embarrassed by losing control when some parts of the community tell them it is natural and they should not need to do anything ... then ... fear of failure when they have needed pain relief.

The Committee heard from Ms Yvonne Hauck (16.2.95) that -

pain is telling our body something, but it is also something that people can manage well if they choose to. However, they are often frightened into thinking that they may not be able to manage ... It is difficult for people once they have had one epidural to go back to the prospect of not having one [the second time] they still have that fear because they have never had to go through the experience of full labour.

The Survey for Mothers25 revealed that pain of labour was reported to be the worst aspect of labour and delivery for 36% of women.

It was suggested to the Committee that removal of fear might lead to more appropriate use of intervention.

If we can change our attitude and remove the "fear"... then we will be able to use intervention and technology only when it is needed.26

2.3.4 Satisfaction

The Survey for Mothers examined satisfaction in relation to antenatal care, care during delivery and postnatal care amongst women who had recently given birth.

Overall, there was a high level of satisfaction with antenatal care and the treatment that mothers had received.

The majority of mothers indicated that they were "treated with respect", "told all they wanted to know" and "felt that they could ask questions" (Table 9, Appendix B). A greater proportion of public patients felt that they were "treated as just another case", had "too little to say" and "would

23 Submission 10 - Dr Ralph Hickling.
24 Submission 30 (supplement) - Mrs Henny Ligtermoet.
26 Submission 23 - Ms Helen Laing.
have liked to have known more”. When compared with other groups, a greater proportion (18%) of both Aboriginal and teenage mothers felt that they had “too little to say” about their antenatal care (Table 10, Appendix B). However, the differences were not statistically significant.

Overall, women were satisfied with the explanations given for the interventions in childbirth. They tended to be less satisfied with explanations about forceps delivery and episiotomies. Aboriginal women and teenage mothers were generally less satisfied with the explanations given than the other groups.

Overall, 60% of mothers had the person they wanted delivering their baby and private patients were more likely to have the person they wanted.

The experience of labour was described as pleasant by only 22% of all women and as tolerable by the majority of respondents (60%) (Table 40, Appendix B).

Brown and Lumley (1994) found that the following factors were highly related to dissatisfaction with intrapartum care -

- lack of involvement in decision making;
- insufficient information;
- a higher score for obstetric intervention;
- and the perception that caregivers were unhelpful.

One in three [Victorian] women were dissatisfied with the care they received in labour and childbirth. Women were more likely to be dissatisfied if they had delivered their babies by caesarean section and if they believed that they had insufficient information from their care-givers.

Paech (1991) reported that 95% of women were satisfied with their childbirth experience. In a survey of 1000 women’s reactions to various methods of obstetric analgesia for vaginal delivery it was revealed that -

- overall satisfaction with childbirth in the early postpartum period was closely related to the quality of pain relief and not obstetric care, the duration of labour or spontaneous delivery.

However, studies cited by Simkin (1989) suggest that -

- satisfaction in childbirth is not necessarily contingent upon the absence of pain ... Many women are willing to experience pain in childbirth, but do not want the pain to overwhelm them.
Women who had a homebirth reported to the Committee -

there is far less intervention in homebirth, and for this reason homebirth mothers and partners report a high satisfaction level of the birth process.\(^\text{34}\)

Martin (1990)\(^\text{35}\) raised the point that -

when one reports that "the great majority" of women were satisfied with a particular aspect of care, it may mean that a substantial number of women are dissatisfied. Dissatisfaction among 10% of all mothers ... means ... there is considerable room for improvement on any aspect of care.

2.3.5 Choice

The Committee received submissions and heard evidence about the woman's right of choice.

A woman has a right to choose her carers, the type of care and place of birth with the health and safety of the mother and infant as a primary consideration.\(^\text{36}\)

There can be no one answer which will suit every woman - but each woman should have the right to choose what happens to her,\(^\text{36}\) including the right to put in writing her requirement for a certain course of action.\(^\text{37}\)

The Expert Maternity Group in the UK believes that the first principle of the maternity services should be -

the woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.\(^\text{38}\)

The Expert Maternity Group also stated -

women should have the opportunity to discuss their plans for labour and birth. Their decisions should be recorded in their birth plans and incorporated into their case notes. Every reasonable effort should be made to accommodate the wishes of the woman and her partner, and to inform them of the services that are available to them.\(^\text{39}\)

Case notes

The Committee heard that women should be allowed to carry their own case notes. In Western Australia, there do not appear to be any legal restrictions which would prevent a woman from carrying her own case notes. The issue appears to one of ownership of the notes. During a visit

\(^{34}\) Submission 62 - South West Homebirth Support Group.


\(^{36}\) Submission 40 - Ms Athalie Johnston and Ms Mary Della-Vedova.

\(^{37}\) Submission 61 - Ms Judith Bowling.


\(^{39}\) ibid. p 31.
to England, the Hon. Ian Taylor heard that this strategy results in greater client satisfaction and helps women to prepare their birth plans.

The Expert Maternity Group addressed the issue of women carrying their own case notes.

When it was first suggested that women should hold their own notes there was strong resistance from some doctors and midwives. As time passed attitudes have changed and it is now becoming normal practice. The evidence on this issue suggests that when a woman is able to hold her own notes she has a stronger sense of control. This control may be as a result of the woman feeling better informed and therefore, more able to be fully involved in discussions about their care, and able to ask questions about what is recorded in the notes.\(^\text{40}\)

There is further discussion of these strategies in Chapter Five, Section 5.8.3.

**Recommendation:**

Women should be allowed to carry their own case notes during pregnancy and childbirth if they wish.

Dr Keith Woollard (9.2.95) told the Committee -

it is perfectly reasonable for the community to expect that the individuals involved will be entitled to a far greater say in what happens.

The desire and ability of women to actively participate in decision-making in their care in pregnancy and labour does not appear to be fully appreciated by many caregivers in Australia.\(^\text{41}\)

According to Chamberlain and Patel (1994)\(^\text{42}\) -

consumers report that they are not always given choice or are presented with choice too late to become involved with the decision-making. Furthermore, it is apparent from a wide range of studies that lack of choice may result in less consumer satisfaction.

Choice without a full understanding of the options is pointless and informed choice depends upon good communication.

It is our belief that consumers are well informed of their choices and rights but are less well informed in relation to the consequences of their choice or demand.\(^\text{43}\)

**Constraints on choice**

\(^\text{40}\) ibid. p 12.

\(^\text{41}\) Submission 51 - Maternity Alliance Inc.


\(^\text{43}\) Submission 50 - Ms Anne-Marie Widermanski, *et al.*
Choice may be restricted depending on the woman's medical circumstances or physical location.

Ms Joan Greenwood (8.8.94) told the Committee -

women really want control to enable them to make their own decisions. The choice to a certain extent must be limited to where they live and the facilities available and ... financial constraints.

To give the total perspective of intervention in childbirth, the public needs to gain access to intervention rates [for] all hospitals, and doctors and obstetricians on an individual basis. Women may then be able to choose their birthing place for the baby based on this knowledge. Homebirth statistics are already made available to the public.44

**Recommendation:**

Women must be given the opportunity by midwives, GPs and specialist obstetricians to make informed decisions about the management of their pregnancy and childbirth. These can be incorporated into a birth plan. In addition, they must be told about the possible consequences of their choice.

Chapter Eleven provides further recommendations which address some of these issues.

### 2.3.6 Continuity of Care

The *Survey for Mothers*45 found that almost half of the women were seen by only one doctor during their pregnancy. Nearly a quarter of respondents saw three or more doctors and the greatest number of doctors reported to have provided care was 21. Ten per cent of private patients in the metropolitan area saw three or more doctors compared with 33% of public patients. A greater proportion of private patients than public patients were satisfied with the numbers of doctors they saw for their antenatal care.

Ms Joan Greenwood (8.8.94) told the Committee -

women ... want more continuity of care so that they do not see a different person at each visit to the clinic or they did not meet someone in labour whom they had never met before.

Chamberlain and Patel (1994)46 indicated that lack of continuity of care or continuity of carer resulted in less consumer satisfaction, "decreasing the likelihood of individual care and good communication". Most women would prefer to see the same caregiver (or one of a small group) over the duration of their pregnancy.

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44 Submission 62 - South West Homebirth Support Group.


Flint and Poulengeris (1987)\(^47\) found that women in the *Know Your Midwife* scheme were more likely to be more satisfied with their antenatal care and to feel more in control in labour than those allocated to standard antenatal care in the hospital.

Martin (1990)\(^48\) conducted a study of women in Edinburgh and found that "84% expressed a preference for continuity of care during pregnancy; that is, they wished to be able to see the same doctor or midwife throughout". Thirty three per cent reported never seeing the same person.

The Committee found that, in general, continuity of care appears to have significant implications for the women's satisfaction with communication between themselves and the health care professionals with whom they come into contact.

Continuity of care and recommendations are further addressed in Chapter Five.

### 2.3.7 Professional Care

The Committee heard from Dr Katrina Alexander (9.2.95) that -

patients perceive that they need to see a specialist, even if they are low-risk. The girls who are well educated, well nourished, who do not need to see a specialist will want to see one;

and

71% of women in Australia are low-risk at the beginning of their pregnancy, but only 18% of deliveries are done by GPs.

Most women in the private hospital system expect their doctor to be present during the labour as well as the delivery. This is the service they pay for.\(^49\)

Dr Graham Smith (9.2.95) agreed that there is a general expectation among patients that they should have a specialist look after them and he felt it was necessary to educate the public. He added -

most people have heard stories which they may find alarming about what happened to a friend looked after by the family doctor, and if only they had gone to a specialist etc. With those scary stories in mind they decide to go straight to the top to avoid those problems.

Dr Smith also said "there is an element of the attitude that they should get their money’s worth and receive deluxe treatment".

The *Survey for Mothers*\(^50\) found that most women (72%) attended antenatal care in a general practitioner's or obstetrician's surgery, approximately 14% of women attended a public hospital clinic and 6% attended the Family Birth Centre at King Edward Memorial Hospital for Women.


\(^{48}\) Martin C. 1990; pp 147-166.

\(^{49}\) Submission 50 - Ms Anne-Marie Widermanski, *et al.*

\(^{50}\) Gilles, *et al.* 1995; p 7.
The average number of antenatal visits was 12. Significantly more country women than metropolitan women received antenatal care from a GP that from a specialist obstetrician.

Sixty per cent of the women surveyed who responded to the question about personnel involved in their labour and delivery indicated that they "received the accoucheur of their choice". A greater proportion of specialists were involved in the delivery of babies of private patients (74%) compared with those of public patients (23%) and midwives delivered the babies of almost twice as many public patients (59%) compared with private patients (32%).

The survey also showed that a high proportion of elderly primiparas were delivered by specialists (64.9%). In contrast, a higher proportion of Aboriginal women (66.7%) and teenage mothers (63.2%) were delivered by a hospital midwife (Table 35, Appendix B). There was a significant difference in the perception of doctors between public and private patients. Doctors were considered very helpful by 77% of private patients compared to only 52% of the public patients. Midwives were considered very helpful by a similar proportion of private (83%) and public patients (78%). The perception of helpfulness of the doctor and midwife was affected by the type of delivery of the woman. The appreciation of the doctor increased with the degree of difficulty of the intervention procedure (Table 39, Appendix B).

The Ministerial Review of Birthing Services in Victoria 1990 found that many women considered that the midwife was their primary source of information and support. Some women were critical of aspects of care including the lack of continuity, communication difficulties and the inability of midwives to act independently.

2.3.8 Knowledge

Women want to receive more information about their pregnancy and childbirth, and the options they have. They also wish to have an opportunity to "debrief" their birth experience. Information and feeling in control are important, not only to a woman's experience of birth but also to her subsequent emotional wellbeing.

Women interviewed by the Health Consumer's Council of WA (Inc.) identified a significant lack of adequate, consistent and unbiased information about childbirth.

Inadequate and inconsistent information in advance of childbirth can lead to dissatisfaction and frustration for women who later realise the extent of their unpreparedness and their reduced capacity to make informed decisions.

íbid. p 22.
íbid. p 24.
Submission 56 - Ms Jacqui Robinson, Ms Liz Burrell and Ms Maxine Drake, Health Consumer's Council of WA (Inc.).
The Health Consumer's Council of WA (Inc.) suggested that technical and statistical information can "provide a useful position from which women can construct their own views and understandings" and that figures should be made available about both hospital and birthing practitioners in respect to procedures undertaken.

2.3.9 Communication

The Victorian Department of Health and Community Services has produced a publication entitled *Pregnancy - Communicating with your doctor* which addresses issues such as choosing a doctor, how to get the most out of a visit to the doctor, informed consent, and what to do if one is unhappy with one's care.

The survey conducted by Martin (1990) highlighted the importance of communication. She concluded that -

> at all stages of maternity care, the quality of communication between women and the professional staff was a crucial determinant of satisfaction of care.

The Committee heard that not all possible options for childbirth are discussed during the antenatal period.

Too much emphasis is placed on women having vaginal deliveries and when complications occur, little advice or support is available to women having caesareans. All the parenthood classes ... paid little or no attention to caesarean births.

Most importantly women should be consulted about what is best for them rather than the current practice of advising them about what is best for them.

The Committee also heard that communication has an impact on litigation. "Legal problems are kept to a minimum if there is real communication between the care giver and client".

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58 Martin C. 1990; pp 147-166.

59 Submission 20 - Mrs Margo Campbell.

60 Submission 4 - Ms Ethel Kempton.

61 Submission 23 - Ms Helen Laing.
RECOMMENDATIONS

Recommendation:

Women should be allowed to carry their own case notes during pregnancy and childbirth if they wish.

Recommendation:

Women must be given the opportunity by midwives, GPs and specialist obstetricians to make informed decisions about the management of their pregnancy and childbirth. These can be incorporated into a birth plan. In addition, they must be told about the possible consequences of their choice.
CHAPTER THREE

STATISTICAL OVERVIEW OF CHILDBIRTH IN WESTERN AUSTRALIA

3.1 INTRODUCTION

Collection of statistical information on pregnancy and childbirth, perinatal and maternal mortality and morbidity in Western Australia and comparison with similar data from other Australian States and Territories and other countries enables monitoring of and research into ways to improve maternity services.

3.2 STATISTICAL COLLECTION IN WESTERN AUSTRALIA

In Western Australia, there are excellent statistical collection systems for perinatal and maternal mortality and morbidity data.

3.2.1 Midwives' Notification System

The Western Australian Midwives' Notification System is the perinatal database which is held by the Health Department of Western Australia. The database contains an individual record for each birth each year. The database is a statutory requirement under the Health Act 1911. Under the legislation, Health (Notifications by Midwives) Regulations 1994, the registered midwife in attendance is required to provide information in a prescribed form for all births which includes demographic details about the mother, information about the pregnancy, labour and delivery and characteristics of the baby. The form is to be completed for all births, liveborn and stillborn of at least 20 weeks gestation or 400 grams birthweight.\(^{62}\)

According to Mrs Vivien Gee (1.12.94), the system is believed to have "more than 99 per cent of all cases recorded there ... and 14 years of computer data".\(^{62}\)

The information is used to provide birth information to community based Child Health Nurses, to monitor trends in birth events, to provide data for planning of maternity and Child Health Services, and to facilitate research into maternal and child health.

To ensure the accuracy of the information contained within the database, the Health Department of Western Australia conducts a validation study of the system periodically to provide information on the reliability of the data for the users of the system and to indicate any areas of the system where errors are occurring and where improvements can be made in the future. The most recent study was conducted in 1993-94 to validate the 1992 data.\(^{63}\)

The Committee endorses the recommendation of the validation study that the National Perinatal Data Advisory Committee discuss the methodology for validation systems.

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63 ibid.
3.2.2 Hospital Morbidity Data System\textsuperscript{64}

The Hospital Morbidity Data System collects information about all admissions to public and private hospitals in Western Australia with information dating back to 1970.

The data consists of -

- basic demographic information, (e.g. age, sex, race, marital status, address);
- hospital information, (e.g. hospital number, whether the patient has been admitted as an acute care or rehabilitation type patient, admission and discharge dates, discharge destination, doctor's code numbers);
- patient information, (e.g. insurance status, referral source, admission type);
- diagnostic information, (e.g. doctor's diagnosis codes, operation codes).

The information is used by the Health Department of Western Australia for purchasing purposes, contracting with the Commonwealth for funding of Defence Force personnel, monitoring contractual agreements with private institutions, treating public patients and for identifying public health problems. The hospitals use the data for financial purposes and for monitoring relative hospital efficiencies and throughput. It is also used extensively by academic and other research orientated groups.

3.2.3 Perinatal and Infant Mortality Database\textsuperscript{65}

Information about all stillbirths and infant deaths is collected from the Midwives' Notification System and the Registrar General's office and maintained in a register in Health Statistics. The database holds information from 1982 onwards. The information is used by the Perinatal and Infant Mortality Committee to describe trends in mortality, to investigate medical practice associated with selected case groups, and to monitor trends over time and between population subgroups.

3.2.4 Maternal Mortality Register

The Maternal Mortality Register keeps data on maternal deaths in Western Australia. It is a statutory requirement under the \textit{Health Act 1911} (Amendment Act 1960) that the Commissioner of Health notifies the Maternal Mortality Committee of any maternal deaths and requests that it investigates the case. The Maternal Mortality Committee investigates each case and advises the health professionals involved of its findings.

3.2.5 Maternal and Child Health Database

The Western Australian Maternal and Child Health Research Database is housed at the Institute for Child Health Research. It is an example of "a working statistical record linkage of birth and..."
paediatric data which serves epidemiological monitoring, surveillance, and analytical purposes for the total population”. The database includes -

- maternal physical and socio-demographic characteristics,
- pregnancy complications,
- perinatal details including infant birth weight and gestational age,
- all causes of deaths (from 20 weeks gestation to one year of age) and information on hospital in-patient morbidity for all children up to six years of age attending hospitals in WA.

All data are linked to individual mother/child pairs and the database is complete for all births in WA from 1980 onwards with new birth cohorts being added on an annual basis. There are also links to the WA Birth Defects Registry and the Cerebral Palsy Register.

### 3.2.6 Birth Defects Registry of Western Australia

The Birth Defects Registry of Western Australia aims to obtain accurate and complete diagnosis on all major and some minor birth defects diagnosed in children up to the age of six years born in WA. Terminations of pregnancy for abnormalities detected by antenatal diagnosis before 20 weeks gestation are also notified to the Registry.

### 3.2.7 Cerebral Palsy Register

The Cerebral Palsy Register records all children with cerebral palsy born and/or living in Western Australia, with data updated to the age of five years.

### 3.3 Perinatal Statistics

#### 3.3.1 Livebirths

In 1993, 25,266 babies (of birthweight > 500g) were born in Western Australia. Of these, 25,143 were livebirths. Most babies resulted from singleton pregnancies (97.3% of total births) while 692 babies resulted from twin or triplet pregnancies.

#### 3.3.2 Perinatal Mortality

A perinatal death is defined as a stillbirth or neonatal death.

The perinatal mortality rate in Western Australia is very low and has fallen over the last 24 years from 27.8/1,000 total births in 1970 to 7.3/1,000 total births in 1993 (Fig 1). The perinatal mortality rate in 1993 was below the national perinatal mortality rate of 8.2/1,000 total births (Table 1).

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66 Stanley FJ, Croft ML, Gibbins J and Read AW. A population database for maternal and child health research in Western Australia using record linkage. Paediatric and Perinatal Epidemiology 1994; 8: 433-447.


Table 1: PERINATAL MORTALITY RATE BY STATE OR TERRITORY OF USUAL RESIDENCE OF MOTHER, 1993

<table>
<thead>
<tr>
<th>State</th>
<th>Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Australia</td>
<td>7.3</td>
</tr>
<tr>
<td>New South Wales</td>
<td>8.5</td>
</tr>
<tr>
<td>Victoria</td>
<td>7.5</td>
</tr>
<tr>
<td>Queensland</td>
<td>8.1</td>
</tr>
<tr>
<td>South Australia</td>
<td>7.6</td>
</tr>
<tr>
<td>Tasmania</td>
<td>9.5</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>19.3</td>
</tr>
<tr>
<td>ACT</td>
<td>7.2</td>
</tr>
<tr>
<td>Australia</td>
<td>8.2</td>
</tr>
</tbody>
</table>

* Rates are per 1000 total births
SOURCE: ABS 1993 Perinatal Deaths, Australia Cat. No. 3304.0

Neonatal mortality rates

A neonatal death is defined as the death of a liveborn infant within 28 days of birth.
In 1993, there were 62 neonatal deaths of babies born in Western Australia.\textsuperscript{70} The neonatal mortality rate has fallen from 5.1/1,000 livebirths in 1984 to 2.5/1,000 livebirths in 1993 (Table 2).\textsuperscript{71}

### Stillbirth rates

A stillbirth is defined as the complete expulsion or extraction from its mother of a product of conception of at least 20 weeks gestation or 400 grams birthweight, which after separation did not show any sign of life.

Stillbirth rates have not changed very much over the last ten years. In 1993, there were 123 stillbirths. The stillbirth rate was 4.9/1,000 total births (Table 2).\textsuperscript{72}

Rates of Aboriginal stillbirth and neonatal mortality are approximately twice those of non-Aboriginals. In 1993, the Aboriginal perinatal mortality rate in Western Australia was 13.2/1,000 total births (Table 2).\textsuperscript{73} The needs of Aboriginal women are examined in Chapter Twelve.

<table>
<thead>
<tr>
<th>Type of Death</th>
<th>Maternal Race</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caucasian</td>
<td>Aboriginal</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>Stillbirth/1,000 total births</td>
<td>4.4</td>
<td>8.3</td>
<td>8.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Neonatal/1,000 livebirths</td>
<td>2.2</td>
<td>4.9</td>
<td>3.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Perinatal/1,000 total births</td>
<td>6.6</td>
<td>13.2</td>
<td>9.7</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight. SOURCE: Midwives’ Notification System.

**Recommendation:**

The reasons for the high Aboriginal perinatal mortality rate must be determined and addressed. More attention must be paid by Aboriginal Medical Services, community health workers and specially designed antenatal services to preconceptual and antenatal education for Aboriginal women because this is an area in which the greatest advances in maternal and infant health can be achieved.

\textsuperscript{70} Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 49.

\textsuperscript{71} *Ibid.* p 49.

\textsuperscript{72} *Ibid.* p 49.

\textsuperscript{73} *Ibid.* p 48.
Cause of deaths

In Western Australia, the main causes of perinatal death were -

- other conditions originating in the perinatal period (68 deaths);
- congenital abnormalities (46 deaths);
- and hypoxia, birth asphyxia and other respiratory conditions (44 deaths).  

A maternal condition affecting the fetus or infant was reported in 58% of Western Australian perinatal deaths. "Complications of the placenta, cord and membranes" was the most common maternal condition (58 deaths) followed by "maternal complications of pregnancy" (24 deaths).

Reasons for a reduction in perinatal mortality

The Committee heard that the reduction in the rates of perinatal mortality over the past ten years may have a number of reasons. The major reasons are improved lifestyle and better antenatal care, particularly for women with medical conditions.

The use of operative procedures has most commonly been rationalised as a means of averting maternal and perinatal death and reducing morbidity ... It has been suggested that ... other factors like systematic antenatal care, hospital deliveries, availability of blood transfusion services, antibiotics, contraception leading to smaller numbers of deliveries per woman and improvement of neonatal intensive care facilities have been of equal importance.

Mrs Vivien Gee (1.12.94) told the Committee "it is difficult to attribute that [the reduction] directly to a change in obstetric practice".

3.3.3 Perinatal Morbidity

Perinatal morbidity is defined as -

- a disorder in the neonate, child or family which occurs as a result of adverse influences or treatments acting either on the fetus during pregnancy and/or the infant during the first four weeks of life.

Conditions associated with high morbidity include preterm birth, perinatal asphyxia, intrauterine growth restriction, perinatal infection and congenital malformations.

According to the National Health and Medical Research Council's (NHMRC) report on perinatal morbidity -

neonatal morbidities/procedures are poorly recorded in perinatal/midwife and hospital morbidity data collections. Therefore, State and Territory health departments should -
establish uniform minimal data sets and definitions within and between states and territories; and

modify hospital morbidity collections to ensure each neonate has his/her own record, improve diagnostic accuracy and enable linkage with perinatal/midwife collections.

3.4 MATERNAL STATISTICS

3.4.1 Maternal Mortality

Maternal mortality in Western Australia is defined in the same way as the NHMRC’s triennial reports on maternal mortality for Australia. Thus "maternal mortality is the death of a woman during pregnancy, childbirth and the puerperium". Maternal deaths are classified into three groups - direct maternal deaths, indirect obstetric deaths and incidental deaths.

In Western Australia, the rate of maternal mortality has fallen dramatically over the last sixty years (Fig 2). It is currently very low and has remained fairly constant for the past ten years. There have been only 13 maternal deaths during that time giving an average mortality rate of 6/100,000 livebirths.

The Committee was very impressed with the low maternal mortality rate in the State, especially because it represents both Aboriginal and non-Aboriginal maternal deaths.

In June 1993, the NHMRC's Report on Maternal Deaths in Australia 1988-1990 indicated that Aboriginal women were eight times more likely to die around pregnancy and childbirth than non-Aboriginal women. The overall maternity mortality rate for Australia between 1988 and 1990 was 12.7/100,000 livebirths while the rate for Aboriginal women was 90/100,000 livebirths.
3.4.2 Maternal Age

In 1993, the number of teenage mothers in Western Australia was 1,490 (6.0%) (Table 3).\textsuperscript{83} This figure has not changed very much over the past 10 years and has fluctuated between 6.0% and 6.7%. The majority of women have their babies when they are 20-34 years of age (Table 3) but more women are having their babies at an older age. For the last 10 years, the percentage of women aged 35 years and older bearing children has almost doubled, from 6.0% in 1984 to 11.2% in 1993.\textsuperscript{84} In 1993, 2.1% of women had their first child when they were 35 years-of-age and older.

\textsuperscript{83} Health Department of Western Australia. \textit{Perinatal Statistics in Western Australia}. 1993; p 16.

\textsuperscript{84} \textit{ibid}. p 55.
Table 3: PARITY AND AGE OF WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Parity</th>
<th>≤19</th>
<th>%</th>
<th>20-34</th>
<th>%</th>
<th>≥35</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td></td>
<td>No.</td>
<td></td>
<td>No.</td>
<td></td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1182</td>
<td>79.3</td>
<td>7935</td>
<td>38.5</td>
<td>526</td>
<td>18.8</td>
<td>9643</td>
<td>38.7</td>
</tr>
<tr>
<td>1-2</td>
<td>303</td>
<td>20.3</td>
<td>10792</td>
<td>52.3</td>
<td>1578</td>
<td>56.5</td>
<td>12673</td>
<td>50.9</td>
</tr>
<tr>
<td>3-4</td>
<td>5</td>
<td>0.3</td>
<td>1662</td>
<td>8.1</td>
<td>546</td>
<td>19.5</td>
<td>2213</td>
<td>8.9</td>
</tr>
<tr>
<td>5+</td>
<td></td>
<td></td>
<td>242</td>
<td>1.2</td>
<td>145</td>
<td>5.2</td>
<td>387</td>
<td>1.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1490</td>
<td>100.0</td>
<td>20631</td>
<td>100.0</td>
<td>2795</td>
<td>100.0</td>
<td>24916</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight.
SOURCE: Midwives' Notification System

3.4.3 Maternal Parity
In 1993, 38.7% of women confined in Western Australia were having their first baby and just over half of the women (50.9%) were having their second or third child (Table 3).

3.4.4 Maternal Race
Most women who gave birth in Western Australia in 1993, were of Caucasian racial origin (87.3%). Aboriginal women comprised 5.7% of mothers and women of all other races comprised 7.0%. A sample of the "other race" group indicated that over two thirds (69.3%) of the women were of Asian racial origin.

3.5 HOSPITAL STATISTICS
3.5.1 Number of Hospitals which have Maternity Patients
Public hospitals
In 1993-1994, one teaching hospital (King Edward Memorial Hospital for Women [KEMH]), eight metropolitan and 64 country hospitals recorded maternity bed days.

Private hospitals
In Western Australia, there are 11 private maternity hospitals. Nine hospitals are located in the metropolitan area and two are in the country. These are Attadale Hospital, Glengarry Hospital, Gosnells Family Hospital, Rockingham Family Hospital, South Perth Community Hospital, Undercliffe Hospital and St Anne's Mercy Hospital, and the St John of God Hospitals in Subiaco, Murdoch, Bunbury and Geraldton.

85 ibid. pp 16-17.
86 ibid. p 7.
87 Health Department of Western Australia. Statement of inpatient and non-patient statistics for hospitals, nursing homes and nursing posts for the year ended June 30, 1994.
3.5.2 Hospital Admissions

In 1993, most deliveries (99.3%) in Western Australia occurred in hospital and there were 24,735 obstetric confinements to hospitals.\(^{88}\) At KEMH there were 6,196 public and 909 private admissions in 1993-1994.\(^{89}\)

In 1993, the leading cause of hospitalisation for women in Western Australia was "pregnancy related conditions" (42.8 admissions per 1,000 person years).\(^{90}\)

3.5.3 Patient Bed Days

In 1993, the total number of maternity bed days for hospitals in Western Australia was 136,842 (Table 4).\(^{91}\)

### Table 4: MATERNITY BED-DAYS FOR HOSPITALS IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Place of Confinement</th>
<th>Number of Women Confined</th>
<th>Average Length of Stay (Days)</th>
<th>Total Bed-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Hospitals</td>
<td>7,023</td>
<td>7.1</td>
<td>49,863</td>
</tr>
<tr>
<td>Metropolitan Govt Hospitals</td>
<td>11,417</td>
<td>5.0</td>
<td>57,085</td>
</tr>
<tr>
<td>Country Govt Hospitals</td>
<td>5,996</td>
<td>5.1</td>
<td>30,580</td>
</tr>
<tr>
<td>All Hospitals</td>
<td>24,436</td>
<td>5.6</td>
<td>136,842</td>
</tr>
</tbody>
</table>

SOURCE: Midwives' Notification System.

In 1993, the average length of stay in hospital for maternity cases was 5.6 days with women confined in private hospitals staying for an average of 7.1 days (Table 4).\(^{92}\) The average length of stay fell during the period from 1989 to 1993. The reduction is more apparent amongst public patients compared to private patients (Table 5). At KEMH, the average length of stay for obstetrics has fallen gradually and was 4.83 days in 1994.\(^{93}\)

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\(^{88}\) Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 12.


\(^{90}\) Health Department of Western Australia. Annual Report 1993-1994; p 23.

\(^{91}\) Health Department of Western Australia. Midwives' Notification System. 1993.

\(^{92}\) *ibid*.

Table 5: AVERAGE LENGTH OF STAY (DAYS) IN HOSPITAL FOLLOWING BIRTH EVENT FOR ALL WOMEN CONFINED, 1989-1993

<table>
<thead>
<tr>
<th>Year</th>
<th>Public Patients</th>
<th>Private Patients</th>
<th>All Women No.%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>6.01</td>
<td>7.24</td>
<td>6.59</td>
</tr>
<tr>
<td>1990</td>
<td>5.65</td>
<td>7.04</td>
<td>6.26</td>
</tr>
<tr>
<td>1991</td>
<td>5.52</td>
<td>7.03</td>
<td>6.15</td>
</tr>
<tr>
<td>1992</td>
<td>5.18</td>
<td>6.95</td>
<td>5.87</td>
</tr>
<tr>
<td>1993</td>
<td>4.88</td>
<td>6.87</td>
<td>5.63</td>
</tr>
</tbody>
</table>

SOURCE: Midwives' Notification System.

3.5.4 Operations and Procedures

A number of obstetric procedures are included in the 100 most frequent operations and procedures performed in Western Australia in 1993-1994 (Table 6). A "lower cervical caesarean section" was the seventh most frequent operation or procedure performed.

Table 6: OBSTETRICS PROCEDURES WITHIN THE 100 MOST FREQUENT OPERATIONS/PROCEDURES PERFORMED IN WESTERN AUSTRALIA, 1993/94

<table>
<thead>
<tr>
<th>Position in 100</th>
<th>Description</th>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Low cervical caesarean section</td>
<td>5135</td>
<td>1.1</td>
</tr>
<tr>
<td>10</td>
<td>Repair of other current obstetric laceration</td>
<td>4528</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>Episiotomy</td>
<td>2764</td>
<td>0.6</td>
</tr>
<tr>
<td>43</td>
<td>Induction of labour by artificial rupture of membranes</td>
<td>1523</td>
<td>0.3</td>
</tr>
<tr>
<td>48</td>
<td>Vacuum extraction with episiotomy</td>
<td>1330</td>
<td>0.3</td>
</tr>
<tr>
<td>71</td>
<td>Other vacuum extraction</td>
<td>865</td>
<td>0.2</td>
</tr>
<tr>
<td>74</td>
<td>Mid. forceps with episiotomy</td>
<td>829</td>
<td>0.2</td>
</tr>
<tr>
<td>97</td>
<td>Other artificial rupture of membranes</td>
<td>623</td>
<td>0.1</td>
</tr>
</tbody>
</table>

SOURCE: Hospital Morbidity Data System
3.6 PLACE OF CONFINEMENT

During 1993, there were 24,916 women confined in Western Australia (Table 7). Most confinements take place in hospitals in the metropolitan area. In 1994, obstetric activity at KEMH increased by 15% "because more women from the outlying areas of Perth began using KEMH instead of suburban hospitals". The Committee heard from Dr Hamish McGlashan (16.2.95) that -

from south of the river and also from Midland, patients come to King Edward, because of that great shortage of people [doctors] to look after uninsured people.

Over the last ten years, the percentage of confinements in metropolitan hospitals has risen from 72.1% in 1984 to 74.5% in 1993. In 1993, 1,512 (6.1%) women, with a country residential address were confined in metropolitan hospitals. Women from country regions close to Perth are more likely to travel to the metropolitan area for delivery than are women from distant country regions. The proportion of confinements in country hospitals has fallen from 27.1% to 24.8% in 10 years. The majority of women were confined in public hospitals. (Table 7).

The Committee was concerned to note the movement of women away from their local communities or regional hospitals for delivery of their babies. It was aware that there are reasons which would justify transfer, e.g. if the woman has been identified as a high-risk case or she wishes to be close to family and friends. However, country women need to be made aware of the excellent care available to them in many country areas through GP obstetricians and midwives and that it is not always necessary to leave their communities.

A study conducted by the Western Australian Centre for Remote and Rural Medicine entitled General Practitioner Obstetric Practice in Rural and Remote Western Australia found that intervention rates for vacuum, forceps and caesarean sections were lower in rural and remote areas of Western Australia compared to statewide figures and there was less use of epidurals. The study also indicated that GPs in remote and rural areas are able to select women that are suitable for local delivery and they transfer high-risk women to specialist centres appropriately.

The Committee strongly supports the policy of GPs in remote and rural areas of transferring high-risk women to specialist centres.

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94 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; p 10.
96 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; p 55.
97 ibid. p 55.
Table 7: PLACE OF CONFINEMENT IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Place of Confinement</th>
<th>Plurality</th>
<th>Plurality</th>
<th>Plurality</th>
<th>Plurality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Metropolitan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching 1</td>
<td>4489</td>
<td>18.3</td>
<td>167</td>
<td>48.8</td>
</tr>
<tr>
<td>Department</td>
<td>7241</td>
<td>29.5</td>
<td>50</td>
<td>14.6</td>
</tr>
<tr>
<td>Private</td>
<td>6518</td>
<td>26.5</td>
<td>96</td>
<td>28.1</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional 2</td>
<td>2803</td>
<td>11.4</td>
<td>21</td>
<td>6.1</td>
</tr>
<tr>
<td>Private</td>
<td>537</td>
<td>2.2</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Other 3</td>
<td>2805</td>
<td>11.4</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Non-Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homebirths</td>
<td>102</td>
<td>0.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BBA 4</td>
<td>79</td>
<td>0.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>24574</td>
<td>100.0</td>
<td>342</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight

1. Teaching Hospital - University Medical School (Teaching Hospitals Act 1955).
2. Country Regional Hospital - Government Hospital with private and public beds.
3. Other country hospitals - includes Government and Board Hospitals.
4. BBA (born before arrival at hospital).

SOURCE: Midwives' Notification System

Recommendation:

There should be an education program through the media, local hospitals and a booklet documenting maternity personnel and services to make country women aware of the facilities and options available to them and of the excellent quality of care they can expect to receive in country areas.

3.6.1 Planned Homebirths

The percentage of planned homebirths in Western Australia has shown little change over the last 10 years, ranging between 0.4% and 0.7% per year.99 In 1991, the percentage of homebirths in Western Australia was 0.6% and was slightly higher than the national average (Table 8).100 In 1993, there were 102 homebirths (0.4%). An additional 26 women planned to have a homebirth but were referred or transferred during pregnancy or labour.

---

99 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; p 55.

Table 8: NUMBER AND PERCENTAGE OF HOMEBIRTHS, STATES AND TERRITORIES, 1991

<table>
<thead>
<tr>
<th>State</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Australia</td>
<td>145</td>
<td>0.6</td>
</tr>
<tr>
<td>New South Wales</td>
<td>273</td>
<td>0.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>136</td>
<td>0.2</td>
</tr>
<tr>
<td>Queensland</td>
<td>176</td>
<td>0.4</td>
</tr>
<tr>
<td>South Australia</td>
<td>51</td>
<td>0.3</td>
</tr>
<tr>
<td>Tasmania</td>
<td>53</td>
<td>0.8</td>
</tr>
<tr>
<td>ACT</td>
<td>64</td>
<td>1.4</td>
</tr>
<tr>
<td>Northern Territory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>898</td>
<td>0.4</td>
</tr>
</tbody>
</table>


The rates of homebirth in other countries varied. In 1991, in the Netherlands, the rate was 31%\(^{101}\), while in England and Wales, the rate was 1.1%\(^{102}\). In the United States, the homebirth rate is thought to be about 1% of all births recorded nationally\(^{103}\).

3.7 INSURANCE STATUS

Over the ten years, from 1983 to 1993, there has been a dramatic decrease in the number of people who have basic hospital insurance (Table 9). Therefore, the number of public patients is increasing. As mentioned previously, in 1993, the majority of women were confined in a public hospital.

Table 9: PROPORTION OF POPULATION WITH BASIC AND SUPPLEMENTARY HOSPITAL INSURANCE, WESTERN AUSTRALIA, 1983 AND 1993

<table>
<thead>
<tr>
<th>Date</th>
<th>Basic Insurance %</th>
<th>Supplementary Insurance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 December 1983</td>
<td>60.5</td>
<td>32.3</td>
</tr>
<tr>
<td>31 December 1993</td>
<td>39.6</td>
<td>34.1</td>
</tr>
</tbody>
</table>


---


\(^{103}\) ibid. p 57.

Figures supplied by King Edward Memorial Hospital for Women (KEMH) indicate that the majority of women who deliver at the hospital are public patients (86.2%).\textsuperscript{105} The \textit{Survey for Mothers} found that 12\% fewer mothers were covered by private insurance compared with the survey population in 1989.\textsuperscript{106}
RECOMMENDATIONS

Recommendation:

The reasons for the high Aboriginal perinatal mortality rate must be determined and addressed. More attention must be paid by Aboriginal Medical Services, community health workers and specially designed antenatal services to preconceptual and antenatal education for Aboriginal women because this is the area in which the greatest advances in maternal and infant health can be achieved.

Recommendation:

There should be an education program through the media, local hospitals and a booklet documenting maternity personnel and services to make country women aware of the facilities and options available to them and of the excellent quality of care they can expect to receive in country areas.
CHAPTER FOUR
INTERVENTION

4.1 INTRODUCTION

The Committee received submissions, backed by evidence from witnesses, that indicated that the current levels of obstetric intervention in Western Australia are too high.

Dr Harry Cohen (16.2.95) told the Committee -

as somebody who has seen the changes I am concerned about intervention rates. I believe they are too high - and unnecessarily so.

In 1994, Dr Marsden Wagner pointed out that Australia had one of the highest obstetric intervention rates in the world and that -

since the three countries with the lowest total operative birth rates had perinatal mortality rates as low or lower than Australia a significant proportion of forceps and caesarean section in Australia is unnecessary.

Intervention in childbirth has contributed to a reduction in the rates of perinatal and maternal mortality and morbidity. However, other factors have also played a part.

It has been suggested that ... other factors like systematic antenatal care, hospital deliveries, availability of blood transfusion services, antibiotics, contraception leading to smaller number of deliveries per woman and improved neonatal intensive care facilities have been of equal importance.

According to Dr Michael Paech-

intervention in childbirth carries a strong community connotation of negativity. Medically, it is ... used in both a positive [ ... to save life or improve outcome] and negative [ ... to assist delivery for non-medical reasons] sense.

According to Stephenson, et al. (1993) -

it is not so much the rate of obstetrical intervention in a population that is at the heart of the issue, but rather the extent to which interventions are used appropriately to maximise the likelihood of a good outcome.

However, they also stated -

---

108 Submission 25 - Dr Jane Fisher.
109 Submission 5 - Dr Michael Paech, Department of Anaesthesia, KEMH.
we can infer that a significant proportion of interventions were unnecessary or only marginally beneficial. Continued increases in rates of ... intervention are unlikely to result in improvements in birth outcome overall and may pose a risk to mothers and their newborns. 111

Witnesses felt -

tries to reduce interventions ... or their unwanted effects are worthy goals provided safety is not compromised, satisfaction is improved and cost is not unacceptable ... Measures seeking to reduce the rates of intervention must have clearly defined objectives and be accountable. 112

There are situations where assisted delivery may be advisable or necessary. These may include -

where maternal conditions necessitate prompt delivery or avoidance of the physiological stresses of labour (eg, pre-eclampsia, eclampsia, severe cardiovascular disease, deteriorating respiratory function, previous classical caesarean section, ruptured uterus or maternal haemorrhage); vaginal delivery imposes a significant infection risk to the fetus (eg, active genital herpes, infection with the human immunodeficiency virus); fetal conditions prompt expedited delivery (eg, fetal distress or asphyxia); dystocia, cephalopelvic disproportion; the condition of the fetus, placenta or membranes does not permit vaginal delivery (eg; malpresentation, severe fetal thrombocytopenia, gross fetal macrosomia, major placenta praevia, vasa praevia, severe abruption). 113

The Committee read a number of submissions which stated that the safety of the mother and the baby are paramount.

Intervention for the primary aim of endeavouring to achieve a safe outcome [of pregnancy, labour/delivery, postnatal period] for both mother and child, is in our opinion appropriate. 114

The overriding consideration of all practitioners is to achieve the successful delivery of a healthy baby to a healthy mother. If this requires intervention, this will be undertaken. 115

Interventions are often appropriate if that intervention leads to safety in the birth of the child without putting the mother at undue risk. 116

112 Submission 5 - Dr Michael Paech.
113 Seymour J. Fetal Welfare and the Law. A report of an inquiry commissioned by the Australian Medical Association and also sponsored by the Royal Australian College of Obstetricians and Gynaecologists, the National Association of Specialist Obstetricians and Gynaecologists, the Australian College of Paediatrics and the Medical Protection Association of Australia. 1995; pp 33-34.
114 Submission 50 - Ms Anne-Marie Widermanski, et al.
115 Submission 35 - Osborne Division of General Practitioners.
116 Submission 16 - Dr Richard Christie and Dr David Roberts.
4.1.1 Definition

Intervention is defined by the Committee as a "clinical procedure in pregnancy and labour, e.g. induction of labour, delivery of the fetus with forceps or by caesarean section". 117

4.1.2 Intervention Rates and Trends

In Western Australia in 1993, less than two thirds (63.5%) of all women confined had a spontaneous vaginal delivery, a further 15.5% had an assisted vaginal delivery (forceps, vacuum extraction or breech manoeuvre) and 21% had a caesarean section (Table 10)118. In the 10 years from 1984-1993, the assisted delivery rate in Western Australia has fallen as the caesarean section rate has increased (Figure 3). In 1993, sixty percent of all women had a spontaneous onset of labour. However, less than one third (28.7%) of all women established labour following spontaneous onset, received no augmentation of labour and achieved a spontaneous vaginal delivery. 119 This indicates that the majority of Western Australian women have some form of intervention during childbirth. This is supported by studies conducted between 1980 and 1990 which showed that "fewer than 40% of Australian women ... had both a spontaneous onset and course of labour and an unassisted delivery". 120

Table 10: TYPE OF DELIVERY, WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Type of Delivery</th>
<th>Number of Deliveries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Vaginal</td>
<td>15,825</td>
<td>63.5</td>
</tr>
<tr>
<td>Assisted Vaginal</td>
<td>3,869</td>
<td>15.5</td>
</tr>
<tr>
<td>Caesarean Emergency</td>
<td>2,763</td>
<td>11.1</td>
</tr>
<tr>
<td>Caesarean Elective</td>
<td>2,459</td>
<td>9.9</td>
</tr>
<tr>
<td>Total</td>
<td>24,916</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight. Women with multiple pregnancies are classified according to the features of the first twin/triplet.

SOURCE: Midwives' Notification System.

There is variation in intervention rates at different hospitals. Table 11 provides data on the place of delivery of women residing in the metropolitan area in 1993, and indicates the rates of different types of deliveries at a number of hospitals.

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118 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; pp 24-26.

119 ibid. p 23.

120 Submission 25 - Dr Jane Fisher.
Fig 1.

Table 11: BIRTHS TO WOMEN RESIDENT IN THE PERTH METROPOLITAN AREA, HOSPITAL AND TYPE OF DELIVERY, 1993

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Breech Man.</th>
<th>Elect. CS</th>
<th>Emerg. CS</th>
<th>Forceps</th>
<th>Vacuum</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armadale/ Kelmscott</td>
<td>0.1</td>
<td>14.4</td>
<td>12.9</td>
<td>9.2</td>
<td>2.1</td>
<td>61.3</td>
</tr>
<tr>
<td>BBA+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Bentley</td>
<td>0.6</td>
<td>15.7</td>
<td>7.4</td>
<td>9.3</td>
<td>4.0</td>
<td>63.1</td>
</tr>
<tr>
<td>Country</td>
<td>-</td>
<td>11.1</td>
<td>-</td>
<td>4.4</td>
<td>2.2</td>
<td>82.2</td>
</tr>
<tr>
<td>Homebirth</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Kalamunda</td>
<td>0.5</td>
<td>9.9</td>
<td>7.5</td>
<td>3.4</td>
<td>5.5</td>
<td>73.3</td>
</tr>
<tr>
<td>KEMH</td>
<td>1.2</td>
<td>8.5</td>
<td>13.5</td>
<td>5.7</td>
<td>7.1</td>
<td>64.1</td>
</tr>
<tr>
<td>Osborne Park</td>
<td>0.3</td>
<td>4.9</td>
<td>6.8</td>
<td>3.3</td>
<td>8.9</td>
<td>75.7</td>
</tr>
<tr>
<td>Private</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100*</td>
</tr>
<tr>
<td>Country</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Private</td>
<td>0.4</td>
<td>15.7</td>
<td>11.0</td>
<td>8.8</td>
<td>14.3</td>
<td>49.9</td>
</tr>
<tr>
<td>Metro</td>
<td>0.6</td>
<td>9.6</td>
<td>10.0</td>
<td>7.6</td>
<td>6.1</td>
<td>66.2</td>
</tr>
<tr>
<td>Rockingham/ Kwinana</td>
<td>1.2</td>
<td>7.4</td>
<td>6.9</td>
<td>5.2</td>
<td>5.8</td>
<td>73.5</td>
</tr>
<tr>
<td>Swan District</td>
<td>0.1</td>
<td>7.4</td>
<td>6.7</td>
<td>2.7</td>
<td>8.4</td>
<td>74.7</td>
</tr>
<tr>
<td>Wanneroo</td>
<td>-</td>
<td>14.0</td>
<td>7.8</td>
<td>8.0</td>
<td>9.0</td>
<td>61.1</td>
</tr>
</tbody>
</table>

* One case only.  + Born before arrival.

SOURCE: Midwives' Notification System.
International comparison of intervention rates

Table 12 examines caesarean section rates, assisted delivery rates and total operative delivery rates in a number of different countries. The Committee found it difficult to obtain very recent data for different countries. McFarlane and Chamberlain (1993)\textsuperscript{121} highlighted the issues of obtaining up-to-date data. Scotland is the only country in the United Kingdom to have a consistent series of data for the last 15 years.

The Committee heard from witnesses and noted from submissions that intervention rates in Australia and Western Australia are much higher than other countries with similar levels of perinatal and maternal mortality.

Table 12: CAESAREAN SECTION, INSTRUMENTAL VAGINAL DELIVERY, AND TOTAL OPERATIVE DELIVERY RATES

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Caesarean Section</th>
<th>Instrumental Vaginal</th>
<th>Total Operative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (WA)</td>
<td>1988</td>
<td>17.0</td>
<td>17.9</td>
<td>34.9</td>
</tr>
<tr>
<td>Australia (WA)</td>
<td>1993</td>
<td>21.0</td>
<td>15.5</td>
<td>36.5</td>
</tr>
<tr>
<td>Australia (Vic)</td>
<td>1988</td>
<td>16.1</td>
<td>14.4</td>
<td>30.5</td>
</tr>
<tr>
<td>Canada (Quebec)</td>
<td>1988</td>
<td>19.5</td>
<td>14.4</td>
<td>33.9</td>
</tr>
<tr>
<td>CSFR*</td>
<td>1988</td>
<td>7.7</td>
<td>1.5</td>
<td>9.2</td>
</tr>
<tr>
<td>Denmark</td>
<td>1987</td>
<td>13.1</td>
<td>9.5</td>
<td>21.6</td>
</tr>
<tr>
<td>Finland</td>
<td>1988</td>
<td>14.4</td>
<td>5.4</td>
<td>19.8</td>
</tr>
<tr>
<td>Greece</td>
<td>1988</td>
<td>16.7</td>
<td>15.2</td>
<td>31.9</td>
</tr>
<tr>
<td>Hungary</td>
<td>1987</td>
<td>10.2</td>
<td>3.3</td>
<td>13.5</td>
</tr>
<tr>
<td>Israel</td>
<td>1987</td>
<td>10.2</td>
<td>4.8</td>
<td>15.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1985</td>
<td>6.5</td>
<td>6.8</td>
<td>13.3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1988</td>
<td>7.2</td>
<td>7.3</td>
<td>14.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>1988</td>
<td>14.4</td>
<td>10.8</td>
<td>25.2</td>
</tr>
<tr>
<td>Scotland</td>
<td>1991</td>
<td>14.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>1987</td>
<td>7.4</td>
<td>3.6</td>
<td>10.0</td>
</tr>
<tr>
<td>United States+</td>
<td>1988</td>
<td>19.1</td>
<td>11.0</td>
<td>30.1</td>
</tr>
<tr>
<td>United States</td>
<td>1992</td>
<td>22.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wales</td>
<td>1990</td>
<td>11.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\* Czech and Slovak Federal Republic; + Washington.  
SOURCES: Adapted from Midwives' Notification System; Stephenson, \textit{et al.} 1993\textsuperscript{122} and McFarlane A and Chamberlain G 1993.\textsuperscript{123}

4.1.3 Reasons for Increased Intervention Rates

The reasons for increased incidence of obstetric intervention are complex. It has been suggested that

\begin{itemize}
  \item McFarlane A and Chamberlain G. \textit{What is happening to caesarean section rates?} Lancet 1993; 342: 1005-1006.
  \item Stephenson, \textit{et al.}. 1993; pp 45-54.
  \item McFarlane A and Chamberlain G. 1993; pp 1005-1006.
\end{itemize}
peer pressure, fear of litigation, lack of skill, rigid hospital policies and inadequate knowledge of research findings are contributing factors.  

Several of these issues are discussed more fully later in this chapter and in Chapters Eight, Nine and Ten. In addition, the Committee heard that other factors might influence intervention rates.

Specialist care

According to Dr Katrina Alexander (9.2.95), many low-risk women go to a specialist rather than a GP for their confinement because they expect specialist care. She added -

\[
\text{this will have an effect on the intervention in childbirth. General practitioners tend to favour gas and pethidine whereas specialists are more likely to use an epidural. That has an effect on the intervention rate.}
\]

Age of mother

Dr Alexander also told the Committee -

\[
\text{many women are putting off having children and there are now a lot of older primary birth women ... These women are much more likely to have intervention during childbirth because they are at greater risk.}
\]

This issue is further discussed later in the chapter.

Cascade of intervention

One of the possible effects of intervention is that once intervention in labour has occurred it may lead to other interventions. Figure 4, adapted from the European Regional Office of the World Health Organization’s booklet Having a baby in Europe,\textsuperscript{125} proposes a "cascade" or chain of diagnostic and therapeutic interventions in perinatal services. The cascade of interventions is not inevitable but there is scientific evidence to link certain interventions to others. The Committee received written examples of the cascade effect.

Just when the labour was starting to progress the mother would say "it's too hard, too painful, I want an epidural". Thirty minutes later you have a mum with an epidural catheter, one or two iv [intravenous] drips, a urinary catheter, a fetal and maternal monitor and paralysis. At first she is happy and you measure contractions for the next 1-2 hours. Then [two] things happen - a [vaginal examination] shows little or no progress ... and the mother starts to get distressed again and calls for more anaesthesia. From that scenario usually resulted a vacuum extraction, forceps or at least trauma and episiotomy.\textsuperscript{126}

\textsuperscript{124} Submission 69 - Ms Carol Thorogood, President, ACMI (WA).


\textsuperscript{126} Submission 6 - Mrs JL Wright.
Figure 4: POSTULATED CHAIN OF DIAGNOSTIC AND THERAPEUTIC INTERVENTION IN PERINATAL SERVICES (CASCADE EFFECT)
Insurance status

The Committee heard that there is a connection between private health insurance and higher levels of intervention.

[In Australia], an approximate doubling of caesarean section and instrumental deliveries rates is seen for private births compared to public births ... A similar doubling of intervention rates for private patients has been observed in the United Kingdom ... It is probable that these high intervention rates are not due to the biological or medical differences between private and public obstetric patients. If anything, private patients are, in general, better nourished, better educated and better prepared for birth; they might be expected to require [and wish for] less intervention in childbirth.\textsuperscript{127}

It is now widely observed both in Australia and other developed countries that the rates of many obstetric interventions, but particularly caesarean delivery, are significantly higher among patients of higher socioeconomic status. This effect is more prominent among those women who hold private health insurance than among those who receive public or state provided care who are usually of lower socioeconomic status.\textsuperscript{128}

Other reasons for intervention are discussed throughout the chapter.

4.2 INTERVENTION

The Committee considered many of the major medical interventions which may occur during pregnancy, labour and childbirth.

4.2.1 Ultrasound

Many women have a routine ultrasound during pregnancy to detect congenital abnormalities, multiple pregnancies, fetal growth disorders, placental abnormalities and errors in the estimation of gestational age. In Western Australia in 1993, 21,149 ultrasound scans were conducted\textsuperscript{129} but data is not collected to indicate if women had more than one ultrasound or at what stage of pregnancy the ultrasound was carried out. A statewide survey in Victoria in 1991-1992, found that 97% of pregnant women had at least one ultrasound scan.\textsuperscript{130} Professor John Newnham (8.2.95) told the Committee "we do not have similar Western Australian data."

**Recommendation:**

Data on the number of ultrasound scans performed and the stage during pregnancy when they are performed should be collected routinely.

\*\textsuperscript{127} Submission 2 - Dr James King, Mater Misericordiae Mothers' Hospital.
\*\textsuperscript{128} Submission 25 - Dr Jane Fisher.
\*\textsuperscript{129} Midwives' Notification System, Health Department of Western Australia 1993.
Side effects

A number of researchers have examined the short and long-term effects of ultrasound.

As part of the Western Australian Pregnancy Cohort (Raine) Study, Professor John Newnham and his colleagues investigated whether doing multiple ultrasound scans on all pregnant women would improve the outcome of pregnancy. They found that -

reducing stress in the woman by this mechanism does not reduce the chance of preterm labour and ... in the hands of King Edward obstetricians at least, a protocol of doing four extra scans, is no better than the clinical judgement of the obstetricians.\textsuperscript{131}

The study also indicated that it was -

plausible that frequent exposure to ultrasound may have influenced fetal growth. Repeated prenatal ultrasound imaging and Doppler flow examinations should be restricted to those women to whom the information is likely to be of clinical benefit.

Ewigman, et al. 1993\textsuperscript{132} found that -

screening ultrasonography did not improve perinatal outcome as compared with the selective use of ultrasonography on the basis of clinical judgement.

They concluded -

the adoption of routine ultrasound screening in the United States would add considerably to the cost of care in pregnancy, with no improvement in perinatal care.

Salvesen, et al. (1992)\textsuperscript{133} showed that the risk of having poor skills in reading and writing was no greater for children whose mothers had been offered routine ultrasonography than for those whose mothers had not been offered the procedure.

Enkin, et al. (1995)\textsuperscript{134} proposed that there are many instances when ultrasound, as a form of care is likely to be beneficial (Table 2, Appendix D). However, they suggested that routine early ultrasound is a form of care with a "trade off between beneficial and adverse effects".


Recommendation:

The Committee endorses the recommendation of the Australian Society of Ultrasound and Medicine that pregnant women be offered a scan at 18 weeks gestation, but that further scans after that time should be done only if there is a medical reason. Scans before 18 weeks should only be done if there is a medical reason. Women should be dissuaded from requesting a scan before 18 weeks for social reasons.

Vaginal scanner

During the Committee's visit to Kalgoorlie, the local obstetrician, Dr Barney McCallum briefed members about the vaginal scanner. Dr McCallum uses a vaginal scanner for every patient. The scanner can provide a picture of a pregnancy as early as at five weeks of gestation. Dr McCallum said that very few obstetricians in WA used them. He is currently trying to obtain one for the Royal Flying Doctor Service. The scanner might help to identify a number of women earlier in their pregnancies and thus provide the opportunity to do antenatal care education at an earlier stage. This is of particular importance for Aboriginal women who often present late in their pregnancy. It would also help with the determination of the accurate date of confinement which is very important for doctors in country areas.

4.2.2 Pain Management

In 1993, 80.7% of women in Western Australia had some form of anaesthesia or analgesia during delivery (Table 13). The majority of women who had no anaesthesia or analgesia had a spontaneous vaginal delivery.

The Committee heard from many witnesses that pain relief is very important to women. The Survey for Mothers found that pain was reported to be the worst aspect of labour and delivery for 35.8% of women and 6% of women specifically reported that their pain control was inadequate. "Consumer surveys both here and overseas indicate that inadequate pain relief during labour is the most common source of dissatisfaction amongst women after childbirth." Many women want to have a pain free labour and the fear of pain may lead them to have unnecessary intervention. Professionals in the field believe this is an area where they can assist women during childbirth.

The Survey for Mothers revealed that 71% of women had used some form of pain relief during labour. A large range of different types of pain control were used (Table 46, Appendix B). The most popular type of pain relief mentioned by women was the "support of the husband/partner"
and 59.6% of women reported that this type of pain relief was "very effective". A further 53.7% of women indicated that the support of a midwife was "very effective".  

The Committee was impressed by the large range of pain relief methods which are or should be available to women during labour and delivery.

**Epidural analgesia (EA)**

In 1993, 8,671 (34.8%) mothers received an epidural at some stage during labour and delivery (Table 13). Of the women having an elective caesarean section, the majority (83.5%) had an epidural,\(^{140}\) 75.2% of women who had an emergency caesarean section had an epidural (100% had an epidural and/or general anaesthesia) and 59.0% of women who had an assisted vaginal delivery had an epidural. Only 14.0% of women who had a spontaneous vaginal delivery had an epidural (14.4% had an epidural and/or general).

The *Survey for Mothers*\(^{141}\) showed that 84.4% of the women who had an epidural found it to be "very effective".

**Table 13:** ANAESTHESIA/ANALGESIA AND TYPE OF DELIVERY FOR WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Type of Anaesthesia/Analgesia</th>
<th>Emergency Caesarean</th>
<th>Elective Caesarean</th>
<th>Assisted Vaginal</th>
<th>Spontaneous Vaginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
<td>190 0.8</td>
<td>4619 18.5</td>
<td>4809 19.3</td>
</tr>
<tr>
<td>Epidural</td>
<td>1749 7.0</td>
<td>2282 9.2</td>
<td>2282 9.2</td>
<td>2215 8.9</td>
<td>8528 34.2</td>
</tr>
<tr>
<td>General</td>
<td>610 2.5</td>
<td>444 1.8</td>
<td>26 0.1</td>
<td>60 0.2</td>
<td>1140 4.6</td>
</tr>
<tr>
<td>Epidural and General</td>
<td>100 0.4</td>
<td>37 0.2</td>
<td>2 -</td>
<td>4 -</td>
<td>143 0.6</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1369 5.5</td>
<td>8927 35.8</td>
<td>10296 41.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2459 9.9</strong></td>
<td><strong>2763 11.1</strong></td>
<td><strong>3869 15.5</strong></td>
<td><strong>15825 63.5</strong></td>
<td><strong>24916 100.0</strong></td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight.  
Women with multiple pregnancies are classified according to the features of the first twin/triplet.  
**SOURCE:** Midwives' Notification System.

\(^{139}\) *ibid.* p 32.  
\(^{140}\) Health Department of Western Australia. *Perinatal Statistics in Western Australia.* 1993; p 30.  
Link between epidural analgesia (EA) and further intervention

There is considerable debate about the connection between EA and further intervention and whether this is part of the "cascade of intervention".

Data from the Western Australian Pregnancy Cohort (Raine) Study[^142] indicated that nulliparous women who have an epidural generally have more intervention than multiparous women who had an epidural. Sixteen per cent of women who had an epidural had a non-elective caesarean section compared to 2.3% of women who did not have an epidural (Appendix C; p 21).

The data showed an increased level of intervention at all levels in women who had an epidural but it could not show a causal effect, only an association. Thus, researchers at KEMH are planning to examine the effect of epidural techniques on the mode of delivery and whether they influence a woman's risk of having an instrumental delivery or caesarean section. Women will be allocated randomly by intention to have or not to have an epidural.

The possible reasons for the connection are unclear but according to Dr Michael Paech (8.2.95) -

> If there is any effect, it may be that the mother's expulsive efforts are not so good, particularly in women having their first labour.

Professor John Newnham (8.2.95) referred to research conducted in the United States by Thorp, et al. (1989).[^143] They did a controlled trial to examine the effect of continuous EA on the incidence of caesarean section for dystocia in nulliparous women, and they found that -

> The incidence of cesarean (sic) section for dystocia was significantly greater in the epidural group (10.3%) than in the non-epidural group (3.8%).

Professor Newnham explained that dystocia is -

> Where a woman fails to progress in labour because the cervix stops dilating ... The mechanism behind this may be that when we block the nervous system we block pain fibres and hence reduce pain, but we are also blocking motor fibres.

The subsequent relaxation of the pelvic floor may lead to dystocia.

The Committee heard that a woman is less likely to have further intervention if she is allowed time for the anaesthetic to wear off sufficiently so that she can feel to push.

Dr Katrina Alexander (9.2.95) stated -

> It is possible to have a normal delivery after an epidural but ... because the sensation has not returned it takes a lot longer to deliver that baby. Often a GP will do that [a normal delivery] but a specialist will not. There is often pressure from some midwives for the doctor to do an assisted delivery.

Dr Michael Paech (8.2.95) told the Committee that -

[^142]: Research findings from the Western Australian Pregnancy Cohort Study, prepared for the Committee by Dr Sharon Evans, Biostatistician, Foundation for Women’s and Infants' Health.

[an] epidural targets the pain more accurately than any other method and relieves it more effectively ... but there are far wider ramifications ... perhaps not just long-term and delivery but because of the fact you need a drip and maybe the baby must be monitored.

He added this leads to "some restriction of the patient's mobility".

A number of researchers suggest that EA may not effect normal deliveries. Naulty, *et al.* (1988)*\(^{144}\) concluded that increasing the percentage of patients who receive EA was not associated with increases in operative deliveries and that continuation of EA throughout the second stage of labour was associated with a decreased number of caesarean and forceps deliveries.

The Committee feels this is an area which requires further investigation.

**Recommendation:**

The Committee supports the research to be conducted by Professor John Newnham and his colleagues into the possible link between epidural analgesia and caesarean section.

**Continuous epidural analgesia vs intermittent epidural analgesia**

The Committee felt that one of the difficulties of continuous EA is that a woman will need close monitoring. It may be difficult for staff to provide such close observation. However, this raises an interesting point that if midwives can be allowed the time to be with a woman, to observe her clinically and be a companion in labour, there may be less need for drug-related pain management.

**Patient controlled epidural analgesia (PCEA)**

Self administered pain relief is becoming increasingly popular and widely used internationally. The methodology of the technique is described by a number of researchers.*\(^{145}\) 146 An epidural catheter is inserted by an anaesthetist and patients receive an initial dose of drugs to establish analgesia or anaesthesia. A pump is attached to the catheter and the patient is able to deliver demand doses to themselves as required.

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Research cited in Paech (1991), suggests that PCEA is effective, produces high patient satisfaction, and reduces drug utilisation and carer requirements. According to Dr Michael Paech (8.2.95) -

one has good quality pain relief while minimising the amount of drug require(d) and...the psychological benefits of being in control and (being) able to regulate the pain control oneself as a patient.

Complaints about epidural management related to delays between intermittent top-ups and staff allowing analgesia to wane in the second stage of labour, suggest that epidural infusions and patient controlled epidural analgesia warrant further evaluation.

Ferrante, et al. (1991) suggested that a "significant dose-sparing effect" (a decrease in the amount of drug required) was associated with the use of demand-dose patient-controlled epidural analgesia as compared with standard continuous epidural infusion for analgesia during labour and delivery.

Anaesthetists say -

the system resulted in a reduced need for assisted deliveries and was safer than conventional epidurals because the doses were much lower.

This technique is currently available at King Edward Memorial Hospital for Women to most women who request it but not all members of the Department of Anaesthesia are familiar with it.

**Recommendation:**

The option of self-administration of analgesia should be made more widely available by training of hospital medical staff. These techniques should also be included in training courses for GP obstetricians and GP anaesthetists.

**Safety and side effects of epidurals**

The Committee heard that there may be long-term effects of epidurals. The main areas which are being examined are whether epidurals are related to back pain and subsequent back function, headache and bladder function and control. Dr Michael Paech (8.2.95) referred to studies which had conflicting findings about the relationship between epidurals and backache and said "we need more information in that area".

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149 Ferrante, et al. 1991; pp 547-552.

**Recommendation:**

More research should be done to determine the relationship between epidurals and short-term and long-term side effects.

**Epidural services**

In 1989, a survey was conducted of epidural practices in all obstetric units in Western Australia.\(^{151}\) Thirteen units (all country hospitals) did not provide an epidural service. Specialist anaesthetists provided an epidural analgesia service to all Perth units and to five out of six regional hospitals. General practitioners serviced six metropolitan and 19 regional/country units. Obstetricians also serviced nine units in the metropolitan and non-metropolitan area. Epidural analgesia was available at any time in 15 units but was subject to availability in the rest.

The Committee heard from Dr Michael Paech (8.2.95) that epidural services are not currently available at some hospitals including some peripheral metropolitan hospitals. "Women were told they could not have an epidural in labour if they decided to deliver at that hospital."

The Committee heard from some country general practitioners who are trained to offer epidurals. The Western Australian Centre for Remote and Rural Medicine (WACRRM) study\(^{152}\) showed that -

epidurals were used at least once in the past year by 58% of GPs. On average country GPs perform an epidural in 12% of deliveries

and

GPs in remote and isolated areas were less likely to use epidurals than GPs in major rural centres.

**Hospital variation in epidural levels**

The Committee heard from Dr Hamish McGlashan (16.2.95) that -

the nursing staff are used to managing people without epidurals, so the overall epidural rate at Osborne Park Hospital - and that includes the caesareans - is about 15 per cent.

In 1993, the epidural rate at Kalgoorlie Regional Hospital was 24.7% and at Woodside Maternity Hospital the rate was 43.3%.\(^{153}\) The Committee heard that the high rate at Woodside Maternity Hospital was probably due to good accessibility to an epidural service.


\(^{152}\) Welch R and Power R. *General Practitioner Obstetric Practice in Rural and Remote Western Australia.* Western Australian Centre for Remote and Rural Medicine 1994; p 17-18.

\(^{153}\) Health Department of Western Australia. *Midwives' Notification System.* 1993.
General anaesthesia

General anaesthesia means that the mother is asleep during delivery. This form of anaesthesia can be rapidly administered and "is of value when speed is important such as when the fetus is severely distressed". The number of women who received a general anaesthetic during labour and delivery was 1,283 (5.1%). "The risks of serious sequelae after general anaesthesia in the pregnant population are considered significantly greater [than for epidurals]." The Committee understands that general anaesthesia is now used only for appropriate medical conditions.

Other anaesthesia/analgesia

In Western Australia in 1993, 10,296 women had some form of anaesthesia/analgesia other than an epidural or general anaesthetic (Table 13). These included narcotic sedation (intramuscular or intravenous); inhalants, such as Entonox; and caudal and pudendal nerve blocks.

Pethidine

Pethidine is the most popular of the narcotics used for pain relief. Researchers cited in Dickersin (1989) found that in 1986, pethidine was the most frequently used obstetric analgesic drug in Europe and North America even though no studies of different opiates have established

155 Submission 5 - Dr Michael Paech.
156 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; p 30.
158 ibid. pp 917-919.
its superiority. Evidence given to the Committee emphasised that pethidine is an acceptable form of pain control for many mothers and carers. Dr Harry Cohen (16.2.95) told the Committee that if pethidine is given at the right time, "for a large number of women it is all they require". The Survey for Mothers found that 75.6% of women who used pethidine thought it was either very or partially effective.

**Nitrous Oxide**

Nitrous oxide has been in use for obstetric analgesia and anaesthesia for over 100 years. Entonox is a combination of nitrous oxide and oxygen. The ideal proportions of nitrous oxide and oxygen has been the subject of concern and debate over the years. The standard currently used is a 50:50 mix. Entonox is available at the Family Birth Centre for pain management.

**Non-drug techniques**

The Committee was interested to hear about the use of non-pharmacological methods of pain relief during labour.

There are many different non-pharmacological methods of pain relief which can be used during labour. Simkin (1989) discussed a number of techniques which include movement and maternal positioning, counterpressure and abdominal decompression, application of heat and cold, hydrotherapy, massage, acupuncture and acupressure, transcutaneous electrical nerve stimulation, education, stress reduction, patterned breathing, relaxation, distraction, visualisation, attention focusing, audioanalgesia, and hypnosis.

All non-drug techniques rely greatly upon the assistance of a companion in labour, who can be the woman's partner, a friend or relative, or the midwife. The strong physical support is linked to strong psychological support.

A number of witnesses expressed opinions about non-drug techniques. Dr Michael Paech (8.2.95) told the Committee -

> techniques of relaxation and distraction ... will help them (women) cope with their labour very much better if they do not use other methods ... they do not relieve the pain but they allow the women to deal with it.

> I believe strongly in the psychological benefits of using non-pharmacological approaches to prepare for the pain of labour and it may be that we have grasped the technological model while neglecting to a degree the non-interventional approaches. There may ... be a place for the promotion and increased availability of teaching ... traditional methods [e.g. Grantley Dick-Read's approach or hypnosis] or newer techniques [biofeedback relaxation].

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160 Dickersin K. 1989; p 921.
162 Submission 5 - Dr Michael Paech.
Relaxation

Mrs Henny Ligtermoet (27.4.95) told the Committee -

the feeling is that the pain associated with the contractions is so strong that you cannot do anything about it and you have to go with it. However, if women can relax during contractions they would cope much better and they would not suffer the enormous pain that so many of them have.

Midwife Care and Support in Labour

Findings from the *Survey for Mothers*\(^ {163} \) showed that the most popular type of pain relief mentioned by mothers was the support of their husband or partner and 59.6% of women reported that this type of pain relief was "very effective". Support of a midwife was the next most popular type of pain control and 53.7% of women stated that this was a "very effective" type of pain control.

The Committee heard from Professor Newnham (8.2.95) about the value of personal contact in pain relief. "An experienced midwife with direct eye contact and coaching on breathing patterns, etc. will have profound effects on pain relief."

Mrs Caroline Flint (29.3.95) told the Committee that she had conducted a randomised controlled trial of the *Know Your Midwife* scheme and had shown that "there was 50% less usage of epidurals by women who knew their midwife".

Massage and Touching

Physical contact and massage appear to be beneficial during labour and childbirth. Massage and touching have not been subjected to careful scientific investigation but the "harmless intervention is well received by labouring women and easily discontinued if she wishes".\(^ {164} \)

Transcutaneous Electrical Nerve Stimulation (TENS)

The Committee heard that TENS is offered as a non-pharmacological option for relief of pain in labour. The TENS unit consists of a hand-held box containing a battery powered generator of electrical impulses. A low-voltage electric current is transmitted to the skin via surface electrodes. TENS is non-invasive, portable, easy to use and can be quickly discontinued if necessary.

TENS is thought to work by -

bombarding the large-diameter afferent [nerve] fibres with innocuous stimuli, thus closing the gate to pain. Furthermore evidence [cited by Simkin] suggests that levels of endorphins are increased in cerebral spinal fluid after low-frequency and high intensity transcutaneous electrical nerve stimulation.\(^ {165} \)

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\(^ {164} \) Simkin P. 1989: p 900.

\(^ {165} \) *ibid.* p 903.
TENS has been subjected to a number of studies which suggest that -

some women find transcutaneous electrical nerve stimulation helpful in labour, but that it does not stand alone as an adequate method of pain relief. The question remains as to whether transcutaneous electrical nerve stimulation's effectiveness might be improved if it were used differently, with different physical parameters, and different electrode size and placement, or if it were used more in conjunction with antenatal preparation and other non-pharmaceutical pain-relieving measures. 166

The Survey for Mothers167 showed that of the 24 women surveyed who had used TENS for pain control, just over one third of them (37.5%) said it was a "very effective" method of pain control.

Hydrotherapy (use of baths and showers)

The Committee heard from a number of witnesses about the benefits of baths and showers to women in labour. The Family Birth Centre at KEMH has a large bath for women to use during labour but they must leave the bath to deliver their baby.

The efficacy of hydrotherapy in reducing labour pain has not been evaluated scientifically and the degree to which it can reduce labour pain is not known. However, "the positive reactions of labouring women to hydrotherapy informally observed by everyone who attends them will ensure continuation of its use". 168 One of the problems expressed by some witnesses is that it is more difficult to monitor a woman who is labouring in a bath or shower.

Exercise (Active Labour) and Maternal Positions

The Survey for Mothers169 showed that over a third of all respondents (196) tried to use walking or position as a form of pain control. One third of those who tried these techniques (31.6%) found them to be "very effective" and half (48%) found them to be "partially effective".

Women may be restricted to bed because of obstetric practices such as electronic fetal monitoring, intravenous hydration and medications. These would render movement out of bed difficult or unsafe. However, being allowed to change position or to walk has the potential to help a woman feel more comfortable, alleviate the source of the pain and to distract her from the pain. Dr Hamish McGlashan (16.2.95) told the Committee "if you keep people walking around, it greatly reduces the need for other analgesia".

Ms Caroline Flint (29.3.95) told the Committee -

if a woman can move around and get herself into a comfortable position when she is in labour, and if she is with somebody she knows, if she has privacy and feels safe and if she is in the dark, then often she does not need anything and does not ask for anything.

If women are encouraged to be more active during labour they will probably require less and lighter drug analgesia. During the Committee's visit to Kalgoorlie, it heard that active labour is part of the philosophy of the midwives at Kalgoorlie Regional Hospital.

166    ibid. p 905.
Recommendation:

Women should be provided with information about and encouraged to use non-pharmacological techniques of pain management.

Education and informed consent

Anaesthetists are aware of the need to provide adequate patient information and to obtain informed consent for procedures. The College of Anaesthetists is producing a policy document on consent. Dr Paech (8.2.95) highlighted to the Committee that it is difficult in the area of epidurals in labour where -

people ... are distressed and in pain [and] are asking for a technique and do not want to know about the pros and cons at that point in time, and they have had other drugs as well which means written consents are not legally valid.

Recommendation:

During their antenatal care women should be given the opportunity to find out more about different types of pain relief, their advantages, side-effects and availability. They require time to consider their options.

4.2.3 Electronic Fetal Heart Rate Monitoring/Cardiotocography (EFM/CTG)

The Committee heard that when electronic fetal heart rate monitoring was introduced, it was not subjected to any randomised controlled trials. It was thought that the technology would solve a lot of problems with the fetus, particularly cerebral palsy which was thought to be due to intrapartum hypoxia. However, the majority of cases of cerebral palsy have now been shown to be caused by an antepartum event.\textsuperscript{170} Therefore, according to Dr Jan Dickinson (26.4.95) "the test could not possibly have dropped the incidence of cerebral palsy".

Statistics

In 1993, in Western Australia, 7,476 women had electronic fetal heart rate monitoring (EFM).\textsuperscript{171} This figure includes all monitoring by cardiotocography (CTG) and not specifically during labour. At KEMH, EFM monitoring was conducted 5,319 times during outpatient attendances in 1993-1994 and 6,068 were conducted on inpatients.\textsuperscript{172} KEMH measured the number of episodes of monitoring rather than the number of women monitored.


\textsuperscript{171} Health Department of Western Australia. Midwives' Notification System. 1993.

\textsuperscript{172} King Edward Memorial Hospital for Women. Annual Review 1994; p 28.
Negative aspects of EFM

The topic of EFM raised a lot of discussion and many witnesses had concerns about its use. They emphasised that EFM can produce false positive results and, if used in low-risk cases, can lead to unnecessary intervention.

The introduction of electronic fetal monitoring to most labour wards in this state has done nothing to improve the overall obstetric outcome. Especially in the private sector, it has been one of the foremost factors in increasing the caesarean section rate, without reducing the already low perinatal mortality and morbidity rates.\textsuperscript{173}

Professor John Newnham (8.2.95) told the Committee -

this technology can produce false positive results. If it is applied to a low-risk case, the chance of a false positive, and hence unnecessary intervention, probably exceeds the chance of producing ... [a true result] by identifying otherwise unexpected fetal hypoxia.

It [the Cochrane Database] shows that the major result of electronic fetal monitoring is an increase in the caesarean section rate. It has no effect on the mortality and morbidity in the groups of mothers who were studied.

Dr Hamish McGlashan (16.2.95) told the Committee that there was a low incidence of CTGs at Osborne Park Hospital.

I do not like CTGs ... On the days when I am on call at Osborne Park Hospital, CTGs are not used unless I am personally consulted ... I am sure there is a direct link between the number of CTGs performed and the number of caesarean sections and other interventions which parallel them.

Interpretation of traces is very difficult. Research has indicated that considerable observer variability occurs which must severely impair the clinical value of the technique.\textsuperscript{174} Professor Fiona Stanley (8.2.95) told the Committee that "intra-observer reliability of electronic fetal monitoring and ability to be able to predict a poor outcome were bad" and "it may be a reasonably good screening test, but it cannot diagnose".

Dr Jan Dickinson (26.4.95) told the Committee -

it is with women who have uncomplicated healthy pregnancies that controversy about electronic fetal monitoring comes in ... because the test has a high false positive rate [and] many abnormalities can be seen that purely reflect a normal fetal response to labour. If you use electronic fetal monitoring in isolation ... without tests such as fetal scalp sampling, the caesarean section rate will increase.

\textsuperscript{173} Submission 63 - Dr Norman Gage.

The introduction of EFM appears to have led to a cascade of further intervention. Studies have shown that monitoring is associated with an increase in the reported occurrence of fetal distress and caesarean sections. Any practising obstetrician that claims to practice safe obstetrics feels constrained to use electronic fetal monitoring. This not only limits the patient's freedom in labour but imposes unnecessary expectations on the supervisor to respond and ultimately to intervene far too often.

Positive aspects of EFM

The Committee did hear some evidence that EFM may be useful in some circumstances, particularly for antepartum monitoring.

Professor John Newnham (8.2.95) told the Committee -

in high-risk cases such as pre-eclampsia and bleeding, etc. the chance of a false positive is less than the chance of producing good by use of the technology.

He added -

if we are to encourage people to deliver women vaginally after a previous caesarean section...it is our responsibility to ensure safety. That safety probably requires that a fetal heart rate monitor be available.

Dr Hamish McGlashan (16.2.95) told the Committee there are certain times when he would use a CTG -

I would use one if everything else was screaming out for a caesarean, but if I could get a CTG which was normal it would persuade me not to do one.

Dr Jan Dickinson (26.4.95) told the Committee that there are circumstances where use of EFM is appropriate.

Classic conditions would be women with thick meconium; intrauterine growth; reduction in amniotic fluid volume; or a preterm fetus and who are labouring. It is clear-cut that those sorts of women benefit greatly from electronic fetal heart rate monitoring.

Policy guidelines and training

The Committee heard from Professor Newnham (8.2.95) that in the early 1980s, the Health Department of Western Australia, in collaboration with KEMH, adopted a policy of restricting EFM in rural hospitals to places that achieved certain requirements. One of those requirements

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177 Submission 63 - Dr Norman Gage.
was that a consultant obstetrician be available. Various centres applied to the Health Department for a monitor. In 1985, a fetal heart rate monitoring course was set up with certification approved by the Health Department. "Doctors and nurses can be ... certified as having been competent to pass this exam and thereby fetal heart rate monitors could be used in towns."

The Committee heard that Kalgoorlie Regional Hospital took legal advice that there must be a EFM machine at the hospital if there is an obstetrician working there. Many hospitals choose not to have or to use EFM machines.

**Fetal scalp blood sampling**

Evidence suggests that "fetal acid-base assessment [by scalp blood sampling] is ... an essential adjunct to fetal heart rate monitoring and should be more widely used".  

The Committee heard from a number of witnesses that EFM should be done in conjunction with fetal scalp blood sampling. Dr Peter Richardson (26.4.95) stated -

> unless fetal blood sampling can be done to detect the acid base balance of the baby and whether there is fetal acidosis, there will be too much intervention when the doctor should not have intervened, however, the real worry is that you will not intervene when you should have.

The Committee heard from Dr Harry Cohen (16.2.95) that fetal scalp blood sampling is not practical -

> unless senior resident staff are available. It is not the sort of thing we could insist [hospitals] must have - or say they cannot be accredited unless they have this facility. It is better that they not monitor [use EFM].

The Committee was concerned that EFM appears to contribute to unnecessary intervention.

**Recommendation:**

The Health Department of Western Australia and King Edward Memorial Hospital for Women, in conjunction with the Royal Australian College of Obstetricians and Gynaecologists and Royal Australian College of General Practitioners, should produce guidelines for the more appropriate use of electronic fetal heart rate monitoring based upon current research findings and the Cochrane Pregnancy and Childbirth Database.

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Other forms of monitoring

Doptone

Dr Peter Richardson (26.4.95) told the Committee that doptones are accurate but -

\[\text{even [they] do not always work ... most independent midwives carry around a little doptone because sometimes it is hard to hear the fetal heart. Nothing is worse than not being able to find a fetal heart beat.}\]

Auscultation

Prentice and Lind (1987)\textsuperscript{179} concluded that continuous fetal monitoring may encourage a false sense of security with regard to the intrauterine state of the fetus and they advise that in low-risk pregnancies, auscultation of the fetal heart would be a reasonable measure. Professor John Newnham (8.2.95) explained to the Committee that continuous intrapartum monitoring in Western Australia is done "on a policy of high-risk cases only ... all labours are otherwise intermittently monitored by auscultation".

4.2.4 Induction

Onset of labour

In 1991, the induction rate in Western Australia was higher than any other state or territory in Australia (Table 14).\textsuperscript{180} The rate has continued to rise and in 1993, labour was induced for 27.5\% of women.\textsuperscript{181} The induction rate in Kalgoorlie was 29.3\%.\textsuperscript{182}

Table 14: ONSET OF LABOUR. ALL CONFINEMENTS, STATES AND TERRITORIES

<table>
<thead>
<tr>
<th>State</th>
<th>Year</th>
<th>Rates (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Spontaneous</td>
</tr>
<tr>
<td>Western Australia*</td>
<td>1993</td>
<td>60.0</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1991</td>
<td>24.9</td>
</tr>
<tr>
<td>New South Wales</td>
<td>1991</td>
<td>64.1</td>
</tr>
<tr>
<td>Victoria</td>
<td>1991</td>
<td>72.2</td>
</tr>
<tr>
<td>Queensland</td>
<td>1991</td>
<td>71.3</td>
</tr>
<tr>
<td>South Australia</td>
<td>1991</td>
<td>71.3</td>
</tr>
<tr>
<td>Tasmania</td>
<td>1991</td>
<td>67.1</td>
</tr>
<tr>
<td>ACT</td>
<td>1991</td>
<td>73.2</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>1991</td>
<td>65.8</td>
</tr>
<tr>
<td>Australia</td>
<td>1991</td>
<td>74.6</td>
</tr>
</tbody>
</table>


\textsuperscript{179} Prentice A and Lind T. \textit{Fetal heart rate monitoring during labour - too frequent intervention, too little benefit?} Lancet 1987; 8572: 1375-1377.

\textsuperscript{180} Lancaster, \textit{et al.} 1994; p 47.

\textsuperscript{181} Health Department of Western Australia. \textit{Perinatal Statistics in Western Australia.} 1993; p 22.

\textsuperscript{182} Health Department of Western Australia. Midwives' Notification System. 1993.
Cervical ripening

No attempts should be made to ripen the cervix unless there are valid grounds for ending a pregnancy artificially.  

The Health Department of Western Australia has prepared an operational instruction which states that -

where induction of labour is indicated and the cervix is unfavourable ... Prostin [Prostaglandin] E2 Gel may be given to dilate the cervix prior to rupturing the membranes. It should not replace rupture of the membranes and an oxytocin infusion where induction of labour is indicated and the cervix is unfavourable.  

According to research findings, vaginal and endocervical (in the cervical canal) administration of Prostaglandin E2 Gel are the current methods of choice.  

Augmentation of labour

In 1993, 24% of all women had their labour augmented by surgical and/or medical intervention following spontaneous onset of the labour. Less than one third (28.7%) of all women who established labour following spontaneous onset, received no augmentation of labour and achieved a spontaneous vaginal delivery (Table 15).  

Table 15: ONSET AND AUGMENTATION OF LABOUR AND TYPE OF DELIVERY FOR WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Labour (women confined)</th>
<th>Type of Delivery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spontaneous Vaginal</td>
<td>Assisted Vaginal</td>
</tr>
<tr>
<td>Spontaneous onset</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>no Augmentation</td>
<td>7142</td>
<td>28.7</td>
</tr>
<tr>
<td>Spontaneous onset</td>
<td>4158</td>
<td>16.7</td>
</tr>
<tr>
<td>and Augmentation</td>
<td>4525</td>
<td>18.2</td>
</tr>
<tr>
<td>Induced onset</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No labour</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15825</td>
<td>63.5</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight.  
Women with multiple pregnancies are classified according to the features of the first twin/triplet.

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186 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; pp 22-23.
SOURCE: Midwives' Notification System.

Amniotomy and oxytocin

Amniotomy (artificial rupture of the membranes) and oxytocin remains the most widely used approach to induction in labour. Evidence from controlled trials has shown that amniotomy plus oxytocin for induction of labour instead of either amniotomy or oxytocin alone is a beneficial form of care.  

Active management of labour

Doctors and midwives often intervene in labour by rupturing the membranes and prescribing oxytocin. Since the 1970s, routine amniotomy and the early use of oxytocin have become part of the package of care referred to as "active management of labour" (this should not be confused with "active" labour on page 53). This is associated in particular with the National Maternity Hospital in Dublin. Other components of the package included strict criteria for the diagnosis of labour, a commitment to never leave a woman unattended in labour and to limit its maximum duration. Recent evidence has shown that the package of active management does reduce the rate of operative interventions for delivery (caesarean sections and operative vaginal deliveries). However, the researchers found that "the effective ingredient seems to be the presence of a companion in labour rather than the performance of amniotomy [rupture of membrane] or administration of oxytocin". Professor John Newnham (8.2.95) agreed that "the Irish simplistic active management of labour was not all it would seem [to be]".

Use of prostaglandins

If the cervix is ripe and a decision is made to use prostaglandin to induce labour, the best option appears to be vaginal administration of Prostaglandin E2 in a viscous gel.

The Committee heard from Dr Peter Richardson (26.4.95) that "the most important thing I want to say about induction is that prostins, rather than syntocinon, should be used". Dr Richardson also felt that the "restrictions by the Commonwealth Government on the use of prostins by only obstetricians is outrageous. Anyone who is competent and properly trained should be able to use them" and he asked the Committee "to consider recommending that the restriction that only obstetricians should use prostins is inappropriate." He suggested that there could perhaps be "some association between general practitioners and obstetricians" for its use. The Health Department's guidelines on the use of Prostaglandin E2 gel addresses restrictions on use.

Dr Richardson reported that since he has been using prostin gel with his patients, his caesarean section rate has fallen.

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189 ibid. p 368.
191 Health Department of Western Australia. Operational Instruction OP 0181/92. 1 July 1992.
Dr Barney McCallum briefed the Committee about his concerns about the use of prostaglandins and their contraindications. He felt that there had been an increase in the number of ruptured uteri in Australia as a result of the use of prostaglandins. He prefers to use artificial rupture of membranes (ARM) and drips which require close supervision of the patient.

**Recommendation:**

GP obstetricians with appropriate obstetric training should be authorised to use the most effective and beneficial drugs available for induction.

**Reasons for induction**

Data from the Western Australian Pregnancy Cohort (Raine) Study\(^{192}\) indicated that the overall reasons for induction were "post date" (19.4%), "all medical" (75.6%), "social convenience" (2.7%) and unknown (2.4%) (Appendix C; p 5). Increased numbers of multiparous women had labour induced for social convenience compared to nulliparous women (4.4% vs 0.9%). In nulliparous women, the increase in induction for social convenience was significant for private patients (3.8% private vs 0.5% public). In the multiparous group, private patients had both an increased number of inductions for social convenience (10.8% private vs 2.95% public) and a decreased rate for post dates (7.2% private vs 20.7% public). The predictors for induction were diabetes, hypertension, private insurance and increasing maternal age.

According to Keirse and Chalmers (1989) -

- the most important decisions to be made in relation to induction of labour do not relate to the methods used to achieve it, but to the justification for pre-empting the spontaneous onset of labour.\(^{193}\)

There are situations where induction of labour is clearly beneficial - "to avoid maternal mortality or morbidity from fulminating preeclampsia; or to avoid prolonging the psychological distress of carrying a dead fetus".\(^{194}\)

The Committee heard many times that inductions are used for the convenience of doctors, women, families or all of these.

So often I see unnecessary inductions of labour in healthy low-risk women for social reasons. Almost always - from my experience - when the natural forces of labour are interrupted and a woman is induced - the outcome is so often intervention.\(^{195}\)

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\(^{192}\) Research findings from the Western Australian Pregnancy Cohort Study, prepared by Dr Sharon Evans.


\(^{195}\) Submission 38 - Ms Dianne Tomlinson.
The *Survey for Mothers*\(^{196}\) found that the most common reason for having the birth induced was "due to the recommendation of the doctor". In addition 10.5% of women who were induced indicated that they had requested the procedure.

The Committee heard that social induction is high in Kalgoorlie because it is an isolated town. Few people have extended families so a woman may be induced because her husband/partner can come into town on his days off or because the woman's mother may be coming at that time. Dr Barney McCallum briefed the Committee that his induction rate is high because he is dealing with high-risk groups and with people from out of town who come to Kalgoorlie just to have their baby.

Stephenson, *et al.* (1993)\(^{197}\) recommend that oxytocin use for reasons of convenience should be discouraged.

**Post-term pregnancy**

The Committee heard from Dr Barney McCallum that what is normal gestation for one woman is not for another and that babies can be due from 37-42 weeks. In some cases he will leave women up to 42 weeks. He felt that only about 8% of women deliver on the calculated due date.

According to Crowley (1989),\(^{198}\) post-term pregnancy, an indication for induction, is a rare occurrence. Moreover, post-term pregnancy is a variant of normal pregnancy and is associated with a good outcome regardless of management. She stated that clinical trials of oxytocin induction for post-term pregnancy have not demonstrated a reduction in perinatal mortality, fetal heart rate abnormalities or depressed Apgar scores.

Slow progress in labour should be stimulated by simple measures. Allowing women the freedom to walk around (active labour) and to eat and drink as tolerated are as effective as oxytocin augmentation.\(^{199}\)

The midwives in Kalgoorlie felt that the expectations of women induced because they are overdue are not the same as for those who are induced early because their partner will be away on the due date. The "social" induction can be more uncomfortable but it is right for the woman and her family and therefore, their choice should be supported.

**Induction leading to other intervention**

Data from the Western Australian Pregnancy Cohort (Raine) Study\(^{200}\) showed that amongst nulliparous women, induction was followed by further intervention. However, it cannot be assumed that induction caused subsequent intervention because the inductions were performed in women who had a higher risk of problems. Only 46.9% of nulliparous women who had labour

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200 Research findings from the Western Australian Pregnancy Cohort Study, prepared by Dr Sharon Evans.
induced had a normal delivery compared to 64.7% who went into spontaneous labour while 80.7% of multiparous women who were induced had a normal delivery compared to 84.8% of women who went into spontaneous labour (Appendix C: pp 3-4). Private patients were more likely to have intervention following induction than public patients.

Oxytocin use rates were associated positively with instrumental delivery but not with caesarean section rates. In addition, Crowley (1989) concluded "contrary to a large amount of evidence from retrospective studies, elective delivery does not increase the likelihood of caesarean section".

4.2.5 Caesarean Section

In 1993, the overall caesarean section rate in Western Australia was 21% (Table 16). Elective caesarean sections accounted for 11.1% and emergency caesarean sections for 9.9%. In 1984, the rate of caesarean section was 13.9%. This has increased steadily over the past 10 years (Figure 5). The rate of caesarean section in Western Australia is one of the highest of all the states and territories (Table 17).

Table 16: TYPE OF DELIVERY AND PARITY OF WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Type of Delivery</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>&gt; 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>4760</td>
<td>49.4</td>
<td>9044</td>
<td>71.4</td>
<td>1711</td>
</tr>
<tr>
<td>Vaginal Assisted</td>
<td>2737</td>
<td>28.4</td>
<td>1023</td>
<td>8.1</td>
<td>94</td>
</tr>
<tr>
<td>Vaginal Caesarean</td>
<td>695</td>
<td>7.2</td>
<td>1798</td>
<td>14.2</td>
<td>239</td>
</tr>
<tr>
<td>Emergency</td>
<td>1451</td>
<td>15.1</td>
<td>808</td>
<td>6.4</td>
<td>169</td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9643</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight.
Women with multiple pregnancies are classified according to the features of the first twin/triplet.
SOURCE: Midwives' Notification System.

Of the women confined by caesarean section in Western Australia in 1993, the highest proportion were at the metropolitan obstetrics teaching hospital and at the private hospitals (Table 18).
Table 17: RATES OF CAESAREAN SECTION, STATES AND TERRITORIES.

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Year</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Australia</td>
<td>1993</td>
<td>21.0</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1992</td>
<td>19.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>1992</td>
<td>18.1</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>1992</td>
<td>18.4</td>
</tr>
<tr>
<td>South Australia</td>
<td>1992</td>
<td>22.1</td>
</tr>
<tr>
<td>New South Wales</td>
<td>1991</td>
<td>16.6</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>1991</td>
<td>17.8</td>
</tr>
<tr>
<td>Tasmania</td>
<td>1991</td>
<td>16.7</td>
</tr>
<tr>
<td>Queensland</td>
<td>1991</td>
<td>20.5</td>
</tr>
</tbody>
</table>

SOURCES: Midwives’ Notification System and Perinatal Statistics in Western Australia 1993. \(^{204}\)

\(^{204}\) ibid. p 26.
Table 18: PLACE OF CONFINEMENT AND CAESAREAN SECTION FOR WOMEN CONFINED IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Elective Women Confinned</th>
<th>Emergency Women Confinned</th>
<th>Total Women Confinned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching 1</td>
<td>436</td>
<td>4656</td>
<td>9.4</td>
</tr>
<tr>
<td>Departmental</td>
<td>726</td>
<td>7291</td>
<td>10.0</td>
</tr>
<tr>
<td>Private</td>
<td>1059</td>
<td>6614</td>
<td>16.0</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional 2</td>
<td>272</td>
<td>2824</td>
<td>9.6</td>
</tr>
<tr>
<td>Private</td>
<td>81</td>
<td>540</td>
<td>15.0</td>
</tr>
<tr>
<td>Other 3</td>
<td>189</td>
<td>2810</td>
<td>6.7</td>
</tr>
<tr>
<td>Non Hospital</td>
<td>-</td>
<td>181</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2763</td>
<td>24916</td>
<td>11.1</td>
</tr>
</tbody>
</table>

Excludes births less than 500 grams birthweight.

1 Teaching Hospital - University Medical School.

2 Country Regional Hospital - Government Hospital with private and public beds.

3 Other country hospitals - includes Government and Board hospitals.

SOURCE: Midwives' Notification System.

Reasons for caesarean sections

The Committee heard from many witnesses that there are numerous factors which may contribute to the increase in the caesarean section rate. Data provided to the Committee from the Western Australian Pregnancy Cohort (Raine) Study\(^\text{205}\) indicated that the main predictors for elective caesarean sections were private insurance and multiparity (Appendix C; p 16). However, if all women who had a previous caesarean section were removed from the data, nulliparous women were 1.3 times more likely to have an elective caesarean section than multiparous women. The main predictors of emergency caesarean sections were induction, diabetes, hypertension, nulliparity, maternal age and maternal height.

\(^{205}\) Research findings from the Western Australian Pregnancy Cohort Study, prepared by Dr Sharon Evans.
Consumer demand has also been cited as a reason for increased caesarean section rates. It has been referred to previously in Chapter Two.

**Parity**

Researchers have shown that the rise in emergency caesarean sections in primiparous women is a major component in the increasing trend in caesarean sections in Western Australia. In 1991, 20.3% of primiparous and 17.2% of multiparous women had a caesarean section in Western Australia. In 1993, 22.3% of primiparous women and 20.1% of multiparous women had a caesarean section. (Table 16).

**Plurality**

In Western Australia in 1991, 18.1% of singleton births, 39.6% of twin births and 100% of other multiple births were delivered by caesarean section. In Western Australia in 1993, 49.7% of twin births were delivered by caesarean section.

**Medical indicators**

According to researchers, cephalopelvic disproportion, breech presentation, fetal distress and repeat caesarean sections were the most common medical indications and accounted for 58% of all caesarean operations. In 1993, in Western Australia, these indicators accounted for 59.9% of complications of labour and delivery for women confined with a caesarean section (Table 19).

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208 Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 27.


210 Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 24.


212 Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 28.
Table 19: COMPLICATIONS OF LABOUR AND DELIVERY FOR WOMEN CONFINED BY CAESAREAN SECTION IN WESTERN AUSTRALIA, 1993

<table>
<thead>
<tr>
<th>Complications of Labour and Delivery</th>
<th>Caesarean Section</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Umbilical Cord Complications</td>
<td>130 2.9</td>
<td>39 1.0</td>
</tr>
<tr>
<td>Cephalopelvic Disproportion</td>
<td>656 14.8</td>
<td>746 19.3</td>
</tr>
<tr>
<td>Breech and other Malpresentations</td>
<td>424 9.5</td>
<td>638 16.5</td>
</tr>
<tr>
<td>Previous Caesarean Section or other uterine surgery</td>
<td>297 6.7</td>
<td>1361 35.2</td>
</tr>
<tr>
<td>Fetal Distress</td>
<td>812 18.3</td>
<td>45 1.2</td>
</tr>
<tr>
<td>Pregnancy Induced Disorders</td>
<td>624 14.0</td>
<td>434 11.2</td>
</tr>
<tr>
<td>Obstruction or Delayed Labour</td>
<td>233 5.2</td>
<td>19 0.5</td>
</tr>
<tr>
<td>Abnormal Forces of Labour</td>
<td>578 13.0</td>
<td>-</td>
</tr>
<tr>
<td>Placental Disorders/Haemorrhage</td>
<td>526 11.8</td>
<td>294 7.6</td>
</tr>
<tr>
<td>Medical/Physiological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>88 2.0</td>
<td>18 0.5</td>
</tr>
<tr>
<td>Previous poor obst. and/or reprod. history</td>
<td>47 1.1</td>
<td>71 1.8</td>
</tr>
<tr>
<td>Other</td>
<td>19 0.4</td>
<td>145 3.7</td>
</tr>
<tr>
<td></td>
<td>10 0.2</td>
<td>58 1.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4444 100.0</strong></td>
<td><strong>3868 100.0</strong></td>
</tr>
</tbody>
</table>

Note: The number of complications exceeds the number of women confined by caesarean section.

SOURCE: Midwives’ Notification System.

*Repeat caesarean sections and vaginal births after a caesarean section (VBAC)*

The rate of repeat caesarean sections in Western Australia is very high and the Committee feels this is an area where reduction in major intervention could occur.

In 1993, in Western Australia, 90.2% of women who were recorded as having had a previous caesarean section or other uterine surgery, had a caesarean section\(^\text{213}\). However, there has been a concern that the data collection for this statistic may not be totally reliable. If women

\(^{213}\) ibid. p 24.
have a vaginal delivery, it is not always recorded whether they had a previous caesarean section. It is known that of the 5,222 women who delivered by caesarean section in 1993, 31.8% had had a previous caesarean section delivery or other uterine surgery.\textsuperscript{214}

### Recommendation:

| The Midwives' Notification form should record whether a woman had a previous caesarean section regardless of how she delivers subsequently. |

According to Notzon (1990) -

information presented on the rate of vaginal births following a cesarean (sic) delivery demonstrates the feasibility of raising VBAC rates in certain countries.\textsuperscript{215}

There is no evidence that a cesarean section is required after a previous transverse low segment cesarean birth. Vaginal deliveries after a cesarean should normally be encouraged wherever emergency surgical capacity is available.\textsuperscript{216}

Professor Con Michael (7.11.94) told the Committee that "there is no doubt that patient requests have been a big factor in repeat caesarean sections".

The Committee heard from a number of sources that a large percentage of these women could have had a vaginal delivery. Dr Harry Cohen (16.2.95) told the Committee "my experience is that 60% [of women] can have a subsequent vaginal birth and 40% would require a repeat caesarean section". Dr Graham Smith (9.2.95) said -

we believe that once a woman has had a caesarean it is very possible to have a satisfactory vaginal confinement and we are trying to do that.

This evidence is backed by studies cited in Myers and Gleicher 1989,\textsuperscript{217} that only one third of the patients who have previously had a caesarean section will require another one if allowed a trial of labour.

### International VBAC trends

According to Notzon, \textit{et al.} (1994),\textsuperscript{218} by 1990, VBAC rates in Norway, Scotland and Sweden were about 50\% (Table 20). Although the VBAC rate remained lower in the United States, impressive gains were made during the 1980s.

\textsuperscript{214} \textit{ibid.} p 24.

\textsuperscript{215} Notzon FC. \textit{International differences in the use of obstetric interventions.} JAMA 1990; 263: 3286-3291.

\textsuperscript{216} WHO Consensus Conference on Appropriate Technology for Birth, Fortaleza, Brazil, 22-26 April 1985.

\textsuperscript{217} Myers SA and Gleicher N. \textit{A successful program to lower cesarean section rates.} N Engl J Med 1988; 319; 1511-1516.

Table 20: RATES OF VAGINAL BIRTH AFTER CAESAREAN DELIVERY, WITH MULTIYEAR INTERVALS CENTRED ON 1980, 1985, AND 1990.*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>56.9+</td>
<td>53.8%</td>
<td>56.2§</td>
</tr>
<tr>
<td>Scotland</td>
<td>38.7</td>
<td>56.3</td>
<td>50.0</td>
</tr>
<tr>
<td>Sweden</td>
<td>40.7</td>
<td>47.4</td>
<td>52.9</td>
</tr>
<tr>
<td>United States</td>
<td>3.0</td>
<td>7.0</td>
<td>19.5</td>
</tr>
</tbody>
</table>

* Vaginal deliveries per 100 births to women with a previous caesarean section delivery.
+ 1980 only, % 1985 only and § 1990 only.

More recent data on VBAC in the United States showed that the rates have risen from 6.6% in 1985 to 25.4% in 1992.219

According to Professor John Newnham (8.2.95) -

> the Americans have now discovered vaginal delivery after caesarean section and have an ever rising VBAC rate which they say should sit between 50 and 70%.

"In Sweden, repeat caesarean sections are not performed unless there are imperative reasons such as serious pelvic abnormality".220

Professor John Newnham (8.2.95) told the Committee that one of the problems with VBAC is -

> if the uterus ruptures - and the risk of that is between 1% and 4% [for a lower segment scar] - surgically it can be exceedingly difficult to deal with.

The Committee heard that women must be closely monitored during a "trial of scar".

**Recommendation:**

More women should be allowed to have a trial of scar where it is medically appropriate, but adequate safety measures must be in place to avoid rupture of the uterus and to cope with one should it occur. The current vaginal birth after caesarean (VBAC) rate should be increased to at least 50% in line with recent research findings.

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**Breech deliveries**

In 1991, 77.6% of breech presentations in singleton confinements were delivered by caesarean section.\(^{221}\) In 1993, in Western Australia, the indications for caesarean section were assessed by examining the complications of labour and delivery. Breech and other malpresentations accounted for 12.8% of complications.\(^{222}\) Of the 1,204 women who had a breech or other malpresentation, 1,062 had a caesarean section and only 142 were delivered vaginally. It should be noted that the women who had caesarean sections may have had additional complications. In 1993, 614 breech presentations were delivered by caesarean section where there were no other recorded complications.\(^{223}\)

According to Dr Marsden Wagner (1994) -

> no more than 50% of breech births should ever require caesarean section. The birth attendant at vaginal breech births needs patience and skill.

Evidence cited by Myers and Gleicher (1988),\(^ {224}\) suggests that safe vaginal delivery of term and preterm breech fetuses can be accomplished in two thirds of cases.

During the visit to Kalgoorlie, Dr Barney McCallum informed the Committee that 4% of all his deliveries are breech manoeuvres. He explained that there is a high attrition rate of skills in breech deliveries if they are not practised regularly.

The Committee was concerned about the large number of breech deliveries which were done by caesarean section. The Committee was told that the trend may be due to lack of experience in the procedure and lack of confidence in professionals skills.

### Recommendation:

More doctors should be encouraged to develop and maintain the skills of breech delivery.

**Fear**

Dr Mark McKenna noted an increase in the number of requests for elective caesarean sections from his private patients. "Fear is often the reason for this request and ... this should be dealt with."\(^ {225}\) Ryding (1993) conducted a study to obtain a better understanding of 33 women who demanded a caesarean section.

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221 Lancaster, et al. 1994; p 51.

222 Health Department of Western Australia. Perinatal Statistics in Western Australia. 1993; p 28.

223 Health Department of Western Australia. Midwives' Notification System. 1993.

224 Myers SA and Gleicher N. 1988; p 1513.

225 Submission 3 - Dr Mark McKenna.
The 28 parous women referred to previous childbirth experiences and feared mainly for intractable labor pain and for the life and health of the child. The most prevalent fear of the five nulliparae was for vaginal rupture.

The women received counselling or psychotherapy and at term, 14 chose a vaginal delivery, 16 chose an elective caesarean and three had an elective caesarean on obstetric indications.\(^{226}\)

**Insurance**

The Committee heard that private patients are more likely to have intervention than public patients. This is confirmed by data obtained from the Midwives’ Notification System (Table 21), KEMH (Table 22) and the *Survey for Mothers* (Table 15, Appendix B) which showed that women with private health insurance have higher rates of caesarean section and operative vaginal deliveries than public patients. Findings from the Western Australian Pregnancy Cohort (Raine) Study also showed that there were marked differences between public and private patients, with the higher rate of elective caesarean section being predominantly amongst private patients.

Despite the fact that there may be an increased number of women with potential medical or obstetric problems among the privately insured, the rates may differ because -

public patients appear to be managed according to "accepted obstetric criteria" for both induction of labour and caesarean section. The possibility that the wish to deliver a perfect baby is more powerful in private practice, and that the tendency to intervene, rather than to wait, is felt more powerfully as doctor and patient have more in common, cannot be excluded.\(^{227}\)

| Table 21: RATES OF CAESAREAN SECTION BY INSURANCE STATUS IN THREE POPULATIONS OF WESTERN AUSTRALIAN WOMEN,\(^*\) 1990-1993 |
|---------------------------------|-------------|-------------|-------------|
| Number                          | Insured %   | Uninsured % | TOTAL %     |
| Primiparous Women               | 37 538      | 25          | 17.5        | 21.4 |
| Low-Risk Women                  | 44 931      | 17.2        | 12.2        | 14.7 |
| Women with Uncompromised Health | 88 329      | 22.2        | 15.7        | 19.0 |

*All women had a singleton pregnancy.

SOURCE: Midwives' Notification System, Submission 70 - Ms Vivien Gee.


Table 22: TYPE OF DELIVERY AND PATIENT INSURANCE STATUS AT KEMH

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>45.3</td>
<td>65.8</td>
<td>45.2</td>
<td>65.6</td>
<td>41.7</td>
<td>65.9</td>
</tr>
<tr>
<td>Operative</td>
<td>24.1</td>
<td>13.3</td>
<td>20.6</td>
<td>13.7</td>
<td>20.6</td>
<td>13.0</td>
</tr>
<tr>
<td>Vaginal</td>
<td>30.6</td>
<td>20.9</td>
<td>34.1</td>
<td>20.8</td>
<td>37.7</td>
<td>21.2</td>
</tr>
</tbody>
</table>


In the United States of America, the caesarean section rate has been shown to depend partly upon the socioeconomic status of the patient. If the woman has to pay for the operation herself, the caesarean section rate is only 16.6% but if private insurance is paying, the figure is over one in four. Hospitals run for a profit have a caesarean section rate of 30.5%. This is not the situation in Sweden, mainly because of the public health system. In Sweden, more than 90% of women attend public antenatal clinics and there are no private obstetric hospitals. "Thus a Swedish woman cannot buy a c.s.[caesarean section]."

The Committee noted that the higher proportion of caesarean sections amongst women with private health insurance may be contributed to by women who have been told that they may require intervention if they become pregnant and who therefore, take out private health insurance as a precaution in case they require specialist care.

**Age of mother**

The Committee heard evidence that age of the mother may have an impact upon the caesarean section rate.

Although there is a superficial link between caesarean section rates and private insurance, this appears to be due almost entirely to patient age. When age is controlled for ... the ... rate does not differ markedly. Women are giving birth at an older age and planning smaller families. There is also an increased probability of multiple births.

A recent study showed that primiparous women aged 35-years-of-age and over were three times more likely to have an elective caesarean section and over two times more likely to have an emergency caesarean section compared to their 20-29 year old counterparts. The increased risk

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230 Submission 3 - Dr Mark McKenna.

231 Submission 70 - Mrs Vivien Gee.
of breech presentation with increased maternal age is likely to be an important contributor to the frequency of elective caesarean section.232

Data from the Midwives’ Notification System showed that the rate of caesarean section increased with age. More than 40% of women aged 35 years or more carrying private health insurance and 32.8% of uninsured women had a caesarean section delivery (Table 23).233

Table 23: PRIMIPAROUS WOMEN WITH SINGLETON PREGNANCY, INSURANCE STATUS, MATERNAL AGE AND TYPE OF DELIVERY, 1990-1993.

| Maternal Age Years | Insured | | | | | | Uninsured | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | Caesarean Section % | Assisted Vaginal % | Normal % | | Caesarean Section % | Assisted Vaginal % | Normal % |
| 10-19 yrs | 11.9 | 28.7 | 59.3 | 12.2 | 19.4 | 68.5 |
| 20-24 yrs | 18.7 | 34.4 | 46.9 | 16.2 | 22.7 | 61.2 |
| 25-29 yrs | 22.9 | 39.2 | 38.0 | 18.9 | 28.2 | 52.9 |
| 30-34 yrs | 29.9 | 38.5 | 31.7 | 23.3 | 30.3 | 46.5 |
| 35-39 yrs | 39.1 | 36.1 | 24.9 | 30.9 | 30.9 | 38.2 |
| 40+ yrs | 53.5 | 28.7 | 17.8 | 46.9 | 24.7 | 28.4 |
| Total | 25.2 | 37.6 | 37.2 | 17.5 | 24.7 | 57.9 |

SOURCE: Midwives’ Notification System, Submission 70 - Ms Vivien Gee.

The Committee noted the association between increased caesarean section rate and age and recognised that there might be a number of other contributing factors including private health insurance, previous caesarean section and parity. Nevertheless, the Committee is concerned about the increase in the caesarean section rate in older women.

**Recommendation:**

Research should be conducted into methods to reduce caesarean section rates in older women and there should be educational material provided to these women to reassure them of the safety of the methods.

Electronic fetal heart rate monitoring

The Committee heard from Professor Con Michael (7.11.94) that "there is no doubt that electronic fetal monitoring has been a contributory factor" in the increase in caesarean sections. This has been more thoroughly discussed in section 4.2.3.

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233 Submission 70 - Mrs Vivien Gee.
Anaesthesia

Anaesthetic techniques have advanced which lead to "reduced risk to mothers and, to a lesser extent, babies during caesarean section procedure". This has been more thoroughly discussed in section 4.2.2.

Assisted reproduction

Patients who have conceived as a result of assisted reproductive technology -

    tend to be older and frequently gone through a long traumatic and expensive process to get pregnant. They are, by and large, not [as] interested in the ins and outs of delivery options as they are in a successful outcome, and often at this stage CS is the safest way.

Outcomes in infertile couples are less favourable and the probability of multiple pregnancies is increased. Although the caesarean section rate is very high for assisted reproduction deliveries, the small numbers of confinements (an estimated 103 in vitro fertilisation [IVF] confinements in 1993) will have little effect upon the overall caesarean section statistics. IVF is further discussed in Section 4.4.

Pre-existing medical conditions of the mother.

Women with pre-existing medical conditions, such as cardiac disorders, essential hypertension, thyroid dysfunction, spinal deformities, diabetes mellitus and epilepsy, have improved access to care so are now more likely to have children and would have an increased probability of intervention in childbirth.

Obstetrician variation

In 1985, the NHMRC noted there were marked variations in caesarean birth rates among individual medical practitioners, with up to six-fold differences in practices of similar size.

Mrs Sue Terry highlighted data from a hospital in the North West of the State.

In 1993, the caesarean rate was [32.2% (18% elective, 14.2% emergency)]. In 1994, the rate was [15.6% (8.4% elective and 7.2% emergency)] ... the only difference was that the one obstetrician left and was replaced by a new obstetrician with different views.
"The most important contribution to reduction lies in the philosophy of the specialist obstetrician ... to intervene only when necessary."\textsuperscript{241}

The Committee heard that since the arrival of Dr Barney McCallum in Kalgoorlie, the caesarean section rate has dropped from 17.9\% in 1990 to 13.1\% in 1993. Dr McCallum does breech and twin deliveries vaginally as often as possible.

Dr Hamish McGlashan (16.2.95) reported to the Committee that the caesarean section rate at Osborne Park Hospital was about 10\%. He attributes the low caesarean section rate to the low incidence of CTG monitoring which occurs at the hospital.

Practitioner attitudes must be recognised to have a strong influence on outcomes of intervention. Therefore, practitioners need to adopt a more positive and optimistic view of childbirth.\textsuperscript{242}

\textbf{Litigation}

Many professionals, such as Professor Michael (7.11.94) believed that "the caesarean section rate is driven upwards to a point by litigation". Litigation is further discussed in Chapter Ten.

\textbf{Risks associated with caesarean sections}

Stephenson, \textit{et al.} (1993) cited research that examined risks associated with caesarean section. These include damage to the uterine blood vessels; accidental extension of the uterine incision; damage to the urinary bladder; anaesthesia accidents; wound infections; maternal mortality; depressed Apgar score; higher rates of neonatal respiratory distress; shortened mean length of gestation; and higher perinatal mortality in subsequent pregnancies.\textsuperscript{243} Bolaji and Meehan (1993) found in a caesarean section survey that -

\begin{quote}
the maternal mortality rate was 11.2/10,000 in the 15-year period and the complications leading to death were ultimately ascribable to primary postpartum haemorrhage.\textsuperscript{244}
\end{quote}

Researchers are now becoming aware of psychological problems which may be linked to intervention in childbirth. Boyce and Todd (1992) found that "when compared with women having spontaneous vaginal or forceps deliveries, women having an emergency caesarean section had more than six times the risk of developing postnatal depression three months postpartum".\textsuperscript{245} This is further discussed in Chapter Six.

Ms Caroline Flint (29.3.95) stated that "women would not choose caesarean section lightly if they actually knew the implications of it".

\textsuperscript{241} Submission 27 - Dr Panos Maouris.

\textsuperscript{242} Submission 14 - Ms Theresa Clifford and Ms Bronwyn Key.

\textsuperscript{243} Stephenson, \textit{et al.} 1993; p 51.

\textsuperscript{244} Bolaji II and Meehan FP. 1993; pp 1-8.

Programs to lower caesarean section rates

Myers and Gleicher (1988) in the United States developed an initiative to try to reduce the number of caesarean deliveries. Their program included -

- a stringent requirement for a second opinion, objective criteria for the four most common indications for caesarean section [dystocia, previous caesarean section, breech presentation and fetal distress] and a detailed review of all cesarean sections and of individual physicians' rates of performing them.

They found that the rates of both primary and repeat caesarean sections decreased. In two years, the rate of primary sections fell significantly from 12% to 6.8% and operative vaginal deliveries also fell from 10.4% to 4.3%.

Sanchez-Ramos, et al. (1990) conducted a study in a teaching hospital serving a "largely high-risk, low income obstetric population". The strategies they introduced were -

- new guidelines for the management of labour for women with previous caesarean sections;
- new guidelines for performing caesareans on first-time mothers, taking into account dystocia, fetal distress and fetal malposition;
- weekly conferences at which medical staff reviewed the reasons for which each caesarean section had been performed.

The caesarean section rate declined from 27.5% in 1986 to 10.5% in 1989 without increasing perinatal mortality rates.

A study at Toowoomba Base Hospital, Queensland found that three interventions accounted for the decrease in the caesarean section rate from 20.5% to 11.1% in consecutive years. These were encouragement of VBACs, active management of labour and extensive regular peer review. They found that the decrease of the caesarean section rate "was not achieved at the expense of the fetus".

In the United States, many hospitals have recognised the financial cost of high operative rates and have begun caesarean section reduction programs by -

- audit and peer review of obstetric decision making. The two key elements of these programs include enhancing the role of midwives and providing support through trained labour companions. Midwives' ... approach is often non-interventionist [and] labour companions have been shown to diminish the rate of intervention substantially.

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Horton also suggested that -

- hospitals should require a second opinion for any section which is not a real emergency;

- reimbursement systems should also ensure that physicians are paid the same amount for vaginal and caesarean section deliveries, in order to remove financial incentives to operate.

In Canada, different strategies were tried to increase the VBAC rate. Simply sending the recommendation to obstetricians or holding caesarean section review committee meetings at the hospital every month where doctors had to defend not doing a VBAC did not increase the rate. However, Lomas, et al. described a strategy of identifying opinion leaders in the obstetric community and providing them with an intensive workshop on VBAC and principles of behaviour change. It was found that the rates of trial of labour and vaginal birth were 46% and 85% higher respectively among physicians educated by an opinion leader.

A program where GP obstetricians and specialists who are delivering the highest numbers of babies are invited to an intensive course on the management of trial of scar may be an effective way to try to increase the VBAC rate.

Money for such a program would need to be separate from the hospitals' budget. This money could come from a special allocation from the Health Department of Western Australia or, as in the case of rural medicine initiatives, from the Lotteries Commission.

Lobbying by pressure groups is also cited as an effective way to reduce intervention rates.

Groups certainly influenced induction rates in the UK, which declined in the latter half of the 1970s and rising caesarean rates have repeatedly been criticised in the lay press.251

**Recommendation:**

Programs to actively reduce caesarean section rates in Western Australia should be trialed in a hospital which will provide active support. The Health Department of Western Australia should allocate funding specifically for such a program.

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4.2.6 Assisted Vaginal Delivery

Table 24: RATES OF OPERATIVE VAGINAL DELIVERY, STATES AND TERRITORIES*

<table>
<thead>
<tr>
<th>State</th>
<th>Year</th>
<th>Rate(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Australia+</td>
<td>1993</td>
<td>15.5</td>
</tr>
<tr>
<td>Western Australia+</td>
<td>1991</td>
<td>16.9</td>
</tr>
<tr>
<td>Victoria#</td>
<td>1992</td>
<td>14.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>1991</td>
<td>14.2</td>
</tr>
<tr>
<td>New South Wales</td>
<td>1991</td>
<td>12.9</td>
</tr>
<tr>
<td>South Australia</td>
<td>1991</td>
<td>14.7</td>
</tr>
<tr>
<td>Queensland</td>
<td>1991</td>
<td>12.0</td>
</tr>
<tr>
<td>Tasmania</td>
<td>1991</td>
<td>13.8</td>
</tr>
<tr>
<td>ACT</td>
<td>1991</td>
<td>13.9</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>1991</td>
<td>9.0</td>
</tr>
<tr>
<td>Australia</td>
<td>1991</td>
<td>13.6</td>
</tr>
</tbody>
</table>

* Operative vaginal delivery includes forceps, vacuum and vaginal breech deliveries.


Rate of assisted vaginal delivery

In 1993, 15.5% of mothers had an operative vaginal delivery which may have been forceps, vacuum extraction or a breech manoeuvre (Table 24). While the rate of caesarean section has steadily increased, the rate of assisted vaginal deliveries has declined gradually over the past 10 years (Figure 3). This pattern has been noted in many countries and may be associated with improvements in the ability to perform caesarean sections.

In 1991, the statewide operative vaginal delivery rate in Western Australia was 16.9% (Table 24) which was higher than any other Australian State and higher than any industrialised country in Europe and North America.

Stephenson, et al. (1993) state that -

there is clear evidence that vacuum extraction is preferable (to forceps delivery). In clinical trials, women allocated to the forceps arm required more anaesthesia and analgesic for pain relief, and were more likely to sustain serious injury compared with women allocated to the vacuum extraction arm.

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The Committee heard that in Kalgoorlie the vacuum extraction rate has increased because it is the preferred method of the local obstetrician, Dr Barney McCallum. Dr McCallum recommended the use of the "Silk Cup" vacuum extractor to the Committee and said it reduces maternal and fetal trauma.

Risks associated with forceps delivery and vacuum extraction

There are a number of documented risks associated with forceps delivery and vacuum extraction. These include maternal pelvic injury; lowered Apgar score; fetal scalp injuries; intracranial injuries; higher use of anaesthesia; analgesia for pain relief; and neonatal hyperbilirubinaemia.

4.2.7 Prevention of Postpartum Haemorrhage

Postpartum haemorrhage is still among the main causes of maternal death in developed countries and contributes significantly to postnatal morbidity in both developing and developed countries. Evidence has shown that women who receive a routine oxytocic injection have a much lower risk of having a postpartum haemorrhage than those women who do not have an oxytocic drug.

The Committee believes that the use of oxytocin is a lifesaving measure.

The two most widely used oxytocic agents are oxytocin and syntometrine (a combination of ergometrine and oxytocin). Researchers who conducted a randomised controlled trial of oxytocin versus oxytocin-ergometrine in active management of the third stage of labour found there were several disadvantages associated with the routine use of oxytocin-ergometrine. Enkin, et al. (1995) include "oxytocics to treat postpartum haemorrhage" in the list of forms of care likely to be beneficial (Table 2, Appendix D).

The practice of physiological management of the third stage of labour has been shown to increase the incidence of postpartum haemorrhage. The Committee was concerned to hear that some community midwives use this technique and do not give an injection of oxytocin, possibly at the request of the mother.

There is a significantly increased incidence of postpartum haemorrhage in homebirths (8% to 10%) compared to hospital births which may result from the infrequent use of oxytocics (approximately 15%).

The Committee heard from Dr Peter Richardson (26.4.95) of the "saving nature of having injectable prostaglandins available when a cataclysmic PPH [postpartum haemorrhage] occurs".

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Enkin, et al. (1995)\(^{263}\) indicate that intramyometrial prostaglandins for severe postpartum haemorrhage is a form of care which is likely to be beneficial (Table 2, Appendix D).

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**Recommendation:**

Women and their birth attendants should be fully informed during the antenatal period about the risks of postpartum haemorrhage and women should be encouraged to have a routine oxytocic injection after delivery, unless there are medical contraindications.

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### 4.2.8 Episiotomy

In Western Australia in 1993, 11,258 (45.5%) of all women confined did not require any form of perineal or vaginal repair while 5,910 (23.7%) of women had an episiotomy repaired.\(^{264}\) Episiotomies appear to be used for a higher proportion of forceps deliveries (80.4%) than vacuum deliveries (56.7%).\(^{265}\)

Episiotomy was the nineteenth most frequent operation performed in Western Australia in 1993/94 (Table 6, Chapter Three). Vacuum extraction with an episiotomy and a mid forceps delivery with an episiotomy were also included within the top 100 procedures.

Enkin, et al. (1995)\(^ {266}\) have indicated that routine or liberal episiotomy is a form of care that is likely to be ineffective or harmful (Table 6, Appendix D). In addition, the Argentine Episiotomy Trial Collaboration Group conducted a randomised controlled trial of routine versus selective episiotomy.\(^{267}\) They found no evidence that routine episiotomy reduces the risk of serious perineal trauma or has any beneficial effect and there is clear evidence that it may cause harm. Wagner (1994)\(^{268}\) reported that one of the recommendations of the WHO (World Health Organization) Consensus Conference on Appropriate Technology for Birth was that "the systematic use of episiotomy is not justified. The protection of the perineum through alternative methods should be evaluated and adopted." The Committee believed that episiotomies were not being conducted routinely and that the decrease could be associated with the increased rate of vacuum extraction in low vaginal delivery.

The Committee noted with interest the increase in the percentage of perineal tears in the last ten years.

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\(^{263}\) Enkin, et al. 1995; p 397.

\(^{264}\) Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 33.

\(^{265}\) ibid. p 34.

\(^{266}\) Enkin, et al. 1995; p 410.


4.2.9 Beneficial Forms of Care and Forms of Care that should be Abandoned.

The Committee heard from witnesses that there has been little research into the use of many technologies or interventions which are currently used.

Rapid uptake of new technologies mean they migrate to become standard practice without having to prove their worth, or to demonstrate a cost benefit to the system. 269

Enkin, et al. (1995) 270 have compiled lists of forms of care based upon their effectiveness (Appendix D). The information comes from the Cochrane Pregnancy and Childbirth Database (see Chapter Nine). The forms of care range from those which have been shown to be beneficial by controlled trials to those which have been shown to be ineffective or harmful.

\begin{center}
\textbf{Recommendation:}
\end{center}

\begin{center}
Professionals working in the area of obstetrics must be familiar with recommended best practice which is based on scientific evidence.
\end{center}

4.3 SUGGESTED WAYS TO REDUCE THE LEVELS OF INTERVENTION

Programs to reduce the rates of caesarean sections have already been discussed in Section 4.2.5 "Programs to lower caesarean section rates". Many of the suggested strategies could apply to other forms of intervention. The Committee also heard evidence about the following ways to reduce intervention rates.

4.3.1 Active Labour

According to Dr Hamish McGlashan (16.2.95) "if you keep people walking around, it greatly reduces the need for other analgesia".

Controlled trials have shown that maternal mobility and change of position are beneficial forms of care in childbirth and that free mobility during labour can augment slow labour (Table 1, Appendix D). 271 The Committee heard from midwives in Kalgoorlie that they practise active labour. They keep women mobile and find that labour progresses more quickly and there is less likelihood of intervention. If women are restricted by a CTG machine or have an epidural, labour will be slowed down.

\begin{flushright}
\textsuperscript{269} Submission 41 - Mrs Sue Terry.
\end{flushright}

\begin{flushright}
\end{flushright}

\begin{flushright}
\textsuperscript{271} ibid. p 392.
\end{flushright}
4.3.2 Community Education

The Committee read in submissions and heard from many witnesses, that women need to be informed about the immediate risks and the long-term effects associated with intervention. Education programs for pregnant women and other groups are discussed in Chapter Eleven.

4.3.3 Consultation

Women should be consulted about what is best for them rather that being advised.

She should be able to feel she is in control of what is happening to her and able to make decisions about her care based on her needs, having discussed matters with the professionals involved.

4.3.4 Labour Support

The Survey for Mothers found that -

the most popular type of pain relief mentioned [by women] was the "support of the husband/partner" ... 60% (183) of women reported it to be very effective. A further 54% (152) of the women who responded stated that the support of the midwife was also very effective.

Enkin, et al. (1995) include "emotional and psychological support during labour and birth" in their list of beneficial forms of care demonstrated by evidence from controlled trials.

A number of submissions and witnesses raised the issue of personal contact and support in labour rather than relying on machines. "They (women) would ... be better served by getting less intervention and more support during pregnancy."

Obstetric technology often has the effect of diverting the focus away from the women to the machinery, hence allowing other subtle changes to be overlooked. The focus is transferred from positive support for the birthing woman to attention to monitors and the data they produce.

Both Professor John Newnham (8.2.95) and Ms Caroline Flint (29.3.95) referred to the beneficial effect of personal contact on pain relief. This has been discussed previously in Section 4.2.2 "Midwife Care and Support in Labour".

272 Submission 4 - Ms Ethel Kempton.
273 ibid.
277 Submission 4 - Mrs Ethel Kempton.
278 Submission 14 - Ms Theresa Clifford and Ms Bronwyn Key.
Research by Killien and Shy (1989) suggested that "the human quality of care may be more important for women in labour than the experiencing of particular procedures". 279

According to Hodnett (1989), 280 professional labour support involves four dimensions: emotional support, informational support, physical support and advocacy while lay labour support providers usually give emotional and physical support.

**Terminology**

There are a number of terms referring to labour support providers other than the woman's partner. These include 281-

- **Doula** - a supportive companion with the labouring woman (not a loved one). She performs no clinical tasks.
- **Monitrice** - A specially trained nurse who provides nursing care, assessment and support.
- **Labour Support Person** - This is synonymous with doula or may refer to an inexperienced friend or relative.
- **Birth Assistant or Labour Assistant** - This may be synonymous with doula but it may also refer to lay women trained in some midwifery skills.

There have been only a few randomised trials of social support. An interim conclusion from available research might be that it is -

inappropriate for hospitals to take it upon themselves to exclude any category of support person from labour and birth. Where women have strong preferences for who should be with them at this time, these should be respected. 282

Chalmers and Wolman (1993) 283 showed that support given by trained or lay untrained female supporters, who are not necessarily known to labouring women -

yields the most extensive, methodologically sound, and consistently positive effects on obstetric and psychosocial outcomes.

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280 Hodnett. (1989) referred to in an article *Labour support terminology,* submitted by E Facer and C Cook. (Supplement to Submission 11.)

281 Wagner M. *Pursuing the birth machine.* 1994; p 196.


They also stated that the use of lay supporters constitutes a low-cost preventive intervention. Research cited by Turner (1991)\textsuperscript{284} showed that the presence of a supportive companion (doula) throughout labour reduced the rates of caesarean section and forceps deliveries among mothers in a Houston hospital. The authors suggested that the physical and emotional benefits of doula support "make a compelling case for the review of current obstetric practices".

\textbf{Recommendation:}

\begin{quote}
\textbf{Women should be encouraged to have social support in labour and to be able to choose a "support person" who is appropriate to their cultural background.}
\end{quote}

\section*{4.3.5 Professional Education}

Professional education may influence the attitudes of health professionals towards intervention in childbirth.

Midwifery students and junior medical staff should be exposed to the different methods of management. Without that they would leave hospital training with a distorted perception about childbirth.\textsuperscript{285}

\section*{4.3.6 Audits}

One of the action points of the Expert Maternity Group in the UK was that "clinical practice should be based on sound evidence and be subject to regular clinical audit".\textsuperscript{286}

Regular audit meetings by midwives and doctors are essential to improve management of labour and to minimise intervention.\textsuperscript{287}

"Hospitals should be required to have regular audits of their intervention rates and these should be made public".\textsuperscript{288}

\section*{4.3.7 Peer Review}

As referred to previously, Maher, \textit{et al.} (1994)\textsuperscript{289} found that regular peer review was one of the components which have reduced the caesarean section rates from 20.5\% to 11.1\% in consecutive years at Toowoomba Base Hospital. The following strategies were utilised -

\begin{itemize}
\item all cases were discussed fully in the labour ward;
\item the caesarean section rate for each month was published in the labour ward;
\item an extensive peer review occurred at three-monthly mortality and morbidity meetings.
\end{itemize}


\textsuperscript{285} Submission 55 - Dr Harry Cohen.


\textsuperscript{287} Submission 27 - Dr Panos Maouris.

\textsuperscript{288} Submission 55 - Dr Harry Cohen.

\textsuperscript{289} Maher, \textit{et al.} 1994; p 392.
4.3.8 Quality Assurance

The Committee heard evidence from Dr Leslie Reti, Chairman of the Royal Australian College of Obstetricians and Gynaecologists' Quality Assurance Committee (12.4.95). Dr Reti discussed the Obstetric and Gynaecology Clinical Indicators that have been developed and introduced into the Australian Council on Health Care Standards Accreditation Program.\(^{290}\)

A clinical indicator is defined as "a measure of the clinical management and outcome of care". Clinical indicators will be used within a hospital to "flag" areas which will then be subject to a more detailed audit.

Obstetric indicator topics are -

- induction of labour other than for defined indications;
- the rate of vaginal delivery after caesarean section;
- primary caesarean section for failure to progress;
- primary caesarean section for fetal distress;
- incidence of an intact lower genital tract in vaginal deliveries for other than forceps delivery, breech delivery or vacuum extraction;
- Apgar score of four or less at five minutes;
- term infant transferred or admitted to a neonatal intensive care unit for reasons other than congenital abnormality;
- postnatal maternal length of stay more than 50% greater than the mean for that hospital for -

(a) vaginal birth; and
(b) caesarean birth.

The Committee heard that a number of hospitals operate quality assurance programs. At King Edward Memorial Hospital for Women, assessment of senior resident medical officers, registrars, and consultant obstetricians and gynaecologists occurs to ensure adequate standards of practice.\(^{291}\)

Quality assurance and improvement programs in all hospitals should regularly look at caesarean and assisted delivery rates. This should be an ongoing part of every unit's teaching and educational programme.\(^{292}\)

4.4 IN VITRO FERTILISATION

The Committee wished to find out about the levels of intervention associated with in vitro fertilisation (IVF) births and whether these could have an impact upon the overall intervention rates for the State.

The Committee heard from Dr Sandra Webb (1.12.94) that estimates in Western Australia indicate that following IVF and related treatments there have been 100 confinements in 1991 and 103 in 1993. This represents about 0.4% of all births in Western Australia.

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\(^{292}\) Submission 55 - Dr Harry Cohen.
A 1988 report showed that for IVF confinements the rates (of birth intervention) were significantly higher than in the general community (caesarean rates were 3.3 times higher for singleton confinements and 3.5 times higher for multiple confinements). Table 25 indicates the increased caesarean section rates for IVF/Gamete Intrafallopian Transfer (GIFT) confinements.

Table 25: TYPE OF DELIVERY AND PLURALITY OF IVF/GIFT CONFINEMENTS

<table>
<thead>
<tr>
<th>Type of Delivery</th>
<th>1</th>
<th>%</th>
<th>2</th>
<th>%</th>
<th>3</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>40</td>
<td>28.6</td>
<td>2</td>
<td>5.1</td>
<td>0</td>
<td>*</td>
<td>42</td>
</tr>
<tr>
<td>Forceps</td>
<td>35</td>
<td>*</td>
<td>5</td>
<td>12.8</td>
<td>0</td>
<td>*</td>
<td>40</td>
</tr>
<tr>
<td>Vacuum</td>
<td>15</td>
<td>*</td>
<td>2</td>
<td>5.1</td>
<td>0</td>
<td>*</td>
<td>17</td>
</tr>
<tr>
<td>Breech</td>
<td>2</td>
<td>*</td>
<td>4</td>
<td>*</td>
<td>0</td>
<td>*</td>
<td>6</td>
</tr>
<tr>
<td>Elective caesarean</td>
<td>28</td>
<td>20.0</td>
<td>15</td>
<td>38.5</td>
<td>3</td>
<td>21.4</td>
<td>46</td>
</tr>
<tr>
<td>Emergency caesarean</td>
<td>20</td>
<td>14.3</td>
<td>11</td>
<td>28.2</td>
<td>11</td>
<td>78.6</td>
<td>42</td>
</tr>
<tr>
<td>Total caesarean</td>
<td>(48)</td>
<td>(34.3)</td>
<td>(26)</td>
<td>(66.6)</td>
<td>(14)</td>
<td>(100.0)</td>
<td>(88)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>140</td>
<td>100.0</td>
<td>39</td>
<td>100.0</td>
<td>14</td>
<td>100.0</td>
<td>193</td>
</tr>
</tbody>
</table>

+9 cases missing information.; * values not supplied by source.


In 1991, the caesarean birth rates in Australia were 37.3% for singleton IVF pregnancies, 50.4% for twin pregnancies and 93.9% for triplet pregnancies. In Western Australia, the rates of caesarean section for singleton confinements were similar but the rates for multiple confinements were lower.

Venn, et al. (1994) concluded that -

high caesarean rates after infertility or IVF and GIFT [gamete intrafallopian transfer] treatment are not explained by maternal age, multiple births, birthweight distribution, number of previous pregnancies or type of infertility. Indications for CS in the infertility group suggest that the threshold for performing a CS is lower in these perceived "precious" pregnancies.

"There is a perception that the option to perform caesarean section may be taken up earlier than in a non-IVF mother."

The Committee heard from Dr Sandra Webb (1.12.94) that to date no current information is available through the newly established IVF Register about the rate of intervention and outcome.

293 Health Department of Western Australia. IVF and related procedures in Western Australia 1983-1987: A demographic, clinical and economic evaluation of participants and procedures. 1988.


296 Submission 50 - Ms Anne-Marie Widermanski, et al.
in IVF births in Western Australia but that it may be possible to link newly registered IVF treatment information for 1993 with the Midwives' Notification System.

The Committee heard that the number of IVF births was so small that they did not have a significant effect upon the intervention rate in WA. However, the needs of these women should not be ignored for it has been perceived that "[IVF] mothers are in need of greater emotional support ... not only to the time of pregnancy, but also to the postnatal period and beyond". 297

**Recommendation:**

Figures on the rate of intervention and outcome in IVF births should be specified in the perinatal statistics for the State.

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297 *ibid.*
RECOMMENDATIONS

Recommendation:

Data on the number of ultrasound scans performed and the stage during pregnancy when they are performed should be collected routinely.

Recommendation:

The Committee endorses the recommendation of the Australian Society of Ultrasound and Medicine that pregnant women be offered a scan at 18 weeks gestation, but that further scans after that time should be done only if there is a medical reason. Scans before 18 weeks should only be done if there is a medical reason. Women should be dissuaded from requesting a scan before 18 weeks for social reasons.

Recommendation:

The Committee supports the research to be conducted by Professor John Newnham and his colleagues into the possible link between epidural analgesia and caesarean section.

Recommendation:

The option of self-administration of analgesia should be made more widely available by training of hospital medical staff. These techniques should also be included in training courses for GP obstetricians and GP anaesthetists.

Recommendation:

More research should be done to determine the relationship between epidurals and short-term and long-term side effects.
Recommendation:

In order to encourage women to deliver at peripheral metropolitan hospitals more medical practitioners should be provided with expertise in epidural analgesia.

Recommendation:

The Australian and New Zealand College of Anaesthetists and the Royal Australian College of General Practitioners should continue to improve the availability and quality of epidural analgesia services in country areas through training initiatives for specialists (obstetricians and anaesthetists) and general practitioners so that women can deliver close to their own homes and their communities.

Recommendation:

Women should be provided with information about and encouraged to use non-pharmacological techniques of pain management.

Recommendation:

During their antenatal care women should be given the opportunity to find out more about different types of pain relief, their advantages, side-effects and availability. They require time to consider their options.

Recommendation:

The Health Department of Western Australia and King Edward Memorial Hospital for Women, in conjunction with the Royal Australian College of Obstetricians and Gynaecologists and Royal Australian College of General Practitioners, should produce guidelines for the more appropriate use of electronic fetal heart rate monitoring based upon current research findings and the Cochrane Pregnancy and Childbirth Database.
Recommendation:

GP obstetricians with appropriate obstetric training should be authorised to use the most effective and beneficial drugs available for induction.

Recommendation:

The Midwives' Notification form should record whether a woman had a previous caesarean section regardless of how she delivers subsequently.

Recommendation:

More women should be allowed to have a trial of scar where it is medically appropriate, but adequate safety measures must be in place to avoid rupture of the uterus and to cope with one should it occur. The current vaginal birth after caesarean (VBAC) rate should be increased to at least 50% in line with recent research findings.

Recommendation:

More doctors should be encouraged to develop and maintain the skills of breech delivery.

Recommendation:

Research should be conducted into methods to reduce caesarean section rates in older women and there should be educational material provided to these women to reassure them of the safety of the methods.
**Recommendation:**

Programs to actively reduce caesarean section rates in Western Australia should be trialed in a hospital which will provide active support. The Health Department of Western Australia should allocate funding specifically for such a program.

**Recommendation:**

Women and their birth attendants should be fully informed during the antenatal period about the risks of postpartum haemorrhage and women should be encouraged to have a routine oxytocic injection after delivery, unless there are medical contraindications.

**Recommendation:**

Professionals working in the area of obstetrics must be familiar with recommended best practice which is based on scientific evidence.

**Recommendation:**

Women should be encouraged to have social support in labour and to be able to choose a "support person" who is appropriate to their cultural background.

**Recommendation:**

Figures on the rate of intervention and outcome in IVF births should be specified in the perinatal statistics for the State.
CHAPTER FIVE
MODELS OF CARE

5.1 INTRODUCTION

In Western Australia, there are a number of choices available to women about where they can have their baby and who will provide care during pregnancy, childbirth and postnatally. Unfortunately, not all choices are available to all women for a number of reasons such as cost, location of service, and medical contraindications. This chapter discusses a number of models of care in Western Australia which the Committee examined during its investigations and looks at some models from other countries.

The Committee heard from Ms Joan Greenwood (8.8.94) that -

in the United Kingdom, there is a group of women who want to opt out of intervention unless it is necessary, and that is seen... as a demand for home birth. Home birth is a worry because of the safety angle in some cases, but it is seen that women do not have a choice in hospital and intervention is applied to them... It seems the only way they can get away from the intervention is to stay out of the institution completely... we should be offering a choice of models of care in an institution, the lowest level of which will approach the home situation in terms of comfort, but will give them the backup of safety.

The Victorian Ministerial Review of Birthing Services *Having a Baby in Victoria* identified eight models of care. They are -

- specialist obstetrician (private hospital);
- standard hospital care (public);
- GP obstetrician (limited public and private hospital);
- shared care;
- team midwifery;
- hospital birth centre;
- home birth (private);
- freestanding birth centre.

5.2 SHARED CARE

5.2.1 Definition

In 1990, the *WA Ministerial Task Force* recommended that "the concept of shared antenatal care between obstetricians, general practitioners and midwives should be actively promoted". Despite the fact the recommendation was made in 1990, little progress has been made in terms of implementation. The Committee believes this is a clear indication as to the difficulty in bringing about change to the existing system. The Committee supports the Task Force's recommendation; however, it believes that "shared care" should be broader than just shared antenatal care. It should

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299 Report of the Ministerial Task Force to review obstetric, neonatal and gynaecological services in Western Australia. 1990; p 15.
include shared care during labour and delivery as well as during the postnatal period.

"Shared care may comprise a combination of groups of health professionals including midwives, GPs and specialist obstetricians." In her submission, Ms Carol Thorogood cited a model at the Hunter Valley Hospital in NSW where eight midwives who were accredited to the hospital provided maternity care for both high and low-risk women, in collaboration with GPs and obstetricians. "The model provides continuity of care by a midwife throughout pregnancy, labour, birth and the puerperium in a cost-effective fashion."  

Ms Enid Facer (16.2.95) told the Committee that -

problems with shared care occur because obstetricians feel we are in competition with them but we are not in competition. We want to be their partners but they do not consider we are qualified highly enough to be their partners ... If doctors could realise we are partners in a team to care for women, the problem would be solved.

During its investigations the Committee heard of a number of shared care models which are being developed in Western Australia.

5.2.2 Mandurah Birth Centre

The Peel Health Services received funding through the federally funded Alternative Birthing Service Program to open the Mandurah Birth Centre to provide women living in the area with a free, alternative place of delivery. Criteria for admission, transfer and exclusion have been prepared to try to ensure that only women with low-risk pregnancies will attend the centre. If women had to be transferred out of the birth centre they would go to either Pinjarra (Murray) District Hospital or Rockingham/Kwinana District Hospital.

The centre incorporates a GP and midwife shared care model which provides continuity of care. It is staffed by a small team of midwives with back up from four local GP obstetricians. GPs run a weekly public antenatal clinic with midwives. The GPs are paid by the local division of general practice. Women attending the unit receive appropriate antenatal education which is relevant to the services available at the Birth Centre.

The centre has adopted a case load management scheme. Midwives are allocated to pregnant women and they care for their clients throughout their entire pregnancy up to and including the birth and during the postnatal period. Both GPs and midwives can deliver babies at the centre. To date all deliveries have been done by midwives.

The Committee heard that there are three groups of clients at the centre -

! some women have their own doctor but they are allocated a midwife who cares for them throughout the pregnancy, delivery and during the postnatal period. The midwife will communicate with the client's doctor;

! public patients attend the antenatal clinic and are seen by one of the four GPs. They may

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300 Submission 69 - Ms Carol Thorogood.
301 ibid.
see a different doctor during their subsequent visits but they are allocated their own midwife. They may choose to have their baby delivered by either a doctor or a midwife;

some women wish to be cared for by a midwife. However, they must see a doctor in order to have blood and other antenatal tests done. A midwife is allocated to each woman and she will provide the primary care.

Midwives will visit clients at home when they go into labour to assess their progress. When the client comes to the centre to deliver, two midwives are always present. They are the client's own midwife as the primary carer and the midwife on duty as the secondary carer. The patient's doctor or the doctor on the roster is notified.

Early discharge is encouraged, so mothers who choose the birth centre option must be prepared to go home very soon after the delivery (6-24 hours) (see Domino Birth, Section 5.4). They are accompanied home by the midwife who has cared for them throughout their pregnancy and delivery. The midwife continues to visit the client every day for 10 days after the birth and then visits or telephones the client once a week for a further 8 weeks. The midwife will refer the client to the child health service. The centre is keeping data on each client on a computer program.

The number of women who deliver at the centre will depend upon the medical and social selection criteria. The staff hope to have 100 clients during 1995-1996 and to increase the number to 200 in 1996-1997.

The Birth Centre was officially opened on 14 August 1995.

5.2.3 Swan Health Service Antenatal Clinic and Birth Centre

The Committee heard that there had been problems at Swan District Hospital and in the Swan Health Service in relation to commissioning a birth centre at Swan District Hospital. "Historically, some local obstetricians have not supported the concept of a family birth centre."

The specific difficulties were -

- funding for midwives' salaries and equipment;
- funding for sessional payments for GP/Obstetricians;
- attracting an appropriate number of GP/Obstetricians to provide backup to the FBC.

The Committee also heard that there was a reduction in the number of women birthing at Swan District Hospital largely as a result of the dramatic decline in the number of GP obstetricians in the area who deliver babies. The number of births has declined from 1208 in 1990 to 945 in 1993. These issues helped to precipitate the Committee's investigations.

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302 Submission 49 - Mr Peter Mott, General Manager, Swan Health Service.
303 ibid.
304 ibid.
In 1995, the Swan Health Service received a grant from the Alternative Birthing Services Program to establish a family birthing centre at Swan District Hospital using a hospital based midwifery team model of care with GP and obstetrician support.

Part of the project involved the setting up of an antenatal clinic with the following objectives -

- to provide antenatal care;
- to provide women with a choice of care giver during pregnancy, birth and puerperium;
- to increase the availability of the obstetric services and facilities of Swan District Hospital to the women of the community;
- to provide comprehensive and objective information in order that women can retain control and make informed decisions related to pregnancy and childbirth;
- to provide a customer-focused obstetric service.

The antenatal clinic commenced on 1 July 1995.

Midwifery care for clients is provided by clinic midwives. Medical cover is provided by a team of GPs who are contracted to the hospital on a sessional basis. They will be on a rotating "on-call" roster.

Women who attend the clinic are assessed by a GP and a midwife at the first visit and then they are offered the appropriate level of care dependent upon their medical suitability and their personal choice (Figure 6). The exclusion and transfer criteria for the birth centre are based upon those of the Family Birth Centre at KEMH (Appendix E). The Swan Health Service anticipates that low-risk women will have most of their antenatal care carried out by midwives. Low-risk women have the option to deliver in the hospital birth centre.

The Committee feels that the new program at Swan District Hospital must be encouraged and supported by the community and the health professionals in the area.

### 5.2.4 Woodside Maternity Hospital

Woodside Maternity Hospital in East Fremantle is a small public hospital which provides both shared care and continuity of care. During a visit to the hospital the Committee heard that the hospital has a birthing centre philosophy in a hospital environment. There are no doctors at the hospital but they can be contracted in as Visiting Medical Officers. All patients must booked in with a doctor but they are told they may be delivered by a hospital midwife. Clients of the midwives in private practice who are accredited to the hospital must also be booked in by a doctor.

The Committee heard that only one specialist and only a few GPs will deliver public patients at the hospital. The Committee believes there needs to be more encouragement for GPs to deliver more public patients in the southern half of the metropolitan area.

Further information about the Committee's visit to Woodside Maternity Hospital is included in Appendix A.
FIGURE 6: SWAN HEALTH SERVICE - MATERNITY MODELS OF CARE

Antenatal clinic women are assessed by a general practitioner and midwife at the first visit. The appropriate model of care is elected according to the woman's choice and medical suitability.

Transfer between models may occur as medically appropriate.
SOURCE: Swan Health Service, Health Department of Western Australia.

5.2.5 Denmark District Hospital

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The Denmark District Hospital submitted a proposal to the Committee to establish a Medical Practitioner - Midwife Community Obstetric and Neonatal Care Service. The proposal was developed in response to the needs of pregnant women and independently practising midwives in the Denmark Community and its aims are -

- to provide medical/midwifery team care and support to women choosing to give birth to their babies at home;
- to provide midwifery follow-up care to women and their babies choosing early discharge after giving birth to their babies in hospital.

The Committee has since heard that the program is now running and there have been 3 homebirths. The midwives involved in the program are employees of the Denmark District Hospital and are insured by the hospital. The program allows women to have a homebirth and be covered by Medicare without having to pay private midwifery fees.

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305 Submission 21 - Ms Aileen Fortescue, Director of Nursing, Denmark District Hospital.
5.2.6 Kalgoorlie Regional Hospital

During informal discussions with staff from Kalgoorlie Regional Hospital, Joanne Davies, a senior midwife, briefed the Committee that she would like to see the establishment of a midwives clinic in Kalgoorlie where shared care with GP obstetricians can be offered. It would allow midwives the opportunity to get to know women better. The clinic could address breastfeeding preparation, social issues and ongoing education and would ensure continuity of care for women. The Committee's visit to Kalgoorlie is further discussed in Appendix A.

5.2.7. Private Sector

The concept of shared care has not been fully explored in the private sector due to demarcation difficulties in relation to payment of fees. The consumer may have the expectation of team care (general practitioner, obstetrician, midwife, paediatrician) but often does not receive it.306

The Committee considers that this appears to be an unfortunate outcome of private health cover.

5.3 BIRTHING CENTRES

Studies from Australia and overseas have examined birth centres and report that -

- team midwifery care [in the Monash Birth Centre] is as safe as the standard maternity care provided within the State [Victoria];307

- a hospital based birth centre [Royal Women's Hospital FBC, Melbourne] offers excellent care to appropriately selected women;308

- birth centers (sic) a safe and acceptable alternative to hospital confinement for selected pregnant women, particularly those who have previously had children, and that such care leads to relatively few caesarean sections.309

Linder-Pelz, et al.(1990)310 studied the Birth Centre at the Royal Hospital for Women in Sydney. They concluded -

- birth centres provide a viable alternative choice to conventional obstetric services for women who are at relatively low obstetric risk as long as there is back-up from the conventional facilities and services.

306 Submission 50 - Ms Anne-Marie Widermanski, et al.
Waldenstrom and Nilsson (1993) examined women’s satisfaction with birth centre care. They found that -

birth centre care successfully meets the needs of women who are interested in natural childbirth and active involvement in their own care, and are concerned about the psychological aspects of birth.

Dr Peter Richardson (26.4.95) told the Committee -

it is pleasing to me that home births centres are erected in major centres, so that women have the advantage of being in a home atmosphere but also have the safety line if an unexpected catastrophe occurs and they can be properly looked after.

Recommendations of the **WA Ministerial Task Force** in 1990 included -

1. that an Alternative Birth Centre (ABC) should be established close to a hospital where emergency perinatal services are available; Woodside Hospital may be an appropriate site for this ABC;
2. the ABC should be autonomously administered and independent midwives, general practitioners, and specialists should have access;
3. the ABC ... should not be located at a Level 3 hospital such as KEMH because the type of care provided at Level 3 is not required for women with low-risk pregnancies;
4. a birthing suite for women with low-risk pregnancies should be established at KEMH, separate from the main delivery suite; this would enable medical and nursing students to obtain experience in low-risk, low-technology birthing techniques and provide another alternative for women with low-risk pregnancies; specialist back-up would be available if required.

### 5.3.1 Family Birth Centre (FBC), King Edward Memorial Hospital for Women.

**Background**

The Family Birth Centre (FBC) at KEMH was set up following the recommendations of the 1990 Ministerial Task Force despite the recommendation that an ABC should not be located at a tertiary hospital. It was established with a grant from the Lotteries Commission in 1991. Midwives are the primary care givers and they conduct all the births at the FBC. They work in a team relationship with an obstetrician and a paediatrician. Women are also seen antenatally by general practitioners who work part-time at the FBC, but doctors are not allowed to consult at the FBC during labour.

**Philosophy**

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The FBC staff are committed to providing optimal care during the childbearing experience. This care is based on the belief that pregnancy, labour and birth are essentially natural physiological processes. The care provided for the mother and baby during pregnancy, labour, birth and the postnatal period should reflect this attitude. Women have the right to seek health care that is not only medically safe for themselves and their baby but also enables childbearing to be a family experience. Each woman, together with her family, is entitled to participate as a member of the team determining the plan of care appropriate to her individual needs. She shares responsibility with the FBC staff for the ultimate goal of a healthy mother, baby and family unit.

Statistics (1 July 1993-30 June 1994)

In 1993/94, 569 women enrolled to deliver at the Family Birth Centre. One hundred and sixty two women (28.5%) were transferred out of the FBC antenatally or prior to the onset of labour and 111 women (19.5%) were transferred out of the centre as intrapartum transfers (50 returned for postnatal care). Therefore, 296 women (52.0%) continued with FBC care and gave birth at the centre (Fig 7).

Nineteen women (3.3%) were transferred out of the FBC after delivering their babies and did not return. Four women (0.7%) were transferred out for medical treatment and then returned to the FBC for postpartum care.

Fourteen babies were transferred out of the FBC and did not return and one baby was transferred out for respiratory distress and then returned to the FBC prior to discharge home with its mother.
FBC STATISTICS Fig 7
The Committee was concerned about the high transfer rate of women out of the FBC but did note that high transfer rates have been recorded at other centres. In the 10 years from 1980-1989, 33% of women were transferred out of the Royal Women’s Hospital FBC during the antenatal (16.6%) or intrapartum period (16.1%). The intrapartum transfer rate noted by Rooks, et al. (1989) was 11.9%. The intrapartum transfer rates reinforce that antenatal screening of women cannot guarantee an uneventful labour. “Clearly 'low-risk' does not equate to 'no risk'.” 316 Linder-Pelz, et al. reported that approximately 30% of birth centre admissions were transferred to the labour ward.

The Committee asked Professor Con Michael (7.11.94) if the criteria for transfer at KEMH were erring on the cautious side and if some patients could be given a longer trial in the birth centre. He replied -

they could [be given a longer trial in the birth centre]. We could review the transfer indications, but one has to be cautious ... I do not need to tell the Committee how quickly things can go wrong ... [it is] important that the birthing centre is in close association with a hospital.

The Committee heard that some women are transferred out of the FBC because there was a medical reason which could not be treated in the centre because doctors are not allowed in. Statistics from the centre for 1993/94 indicated that most of the women who were transferred out of the centre went on to have a spontaneous vaginal delivery (80.2%).319 These women might have been able to continue their care at the FBC if a doctor had been able to examine them there.

**Recommendation:**

The Family Birth Centre (FBC) midwives must be allowed to consult with a GP obstetrician or relevant medical specialist at the FBC if there are medical indicators which require a medical opinion rather than having a patient transferred over to the labour ward for a medical reason. However, the midwife is the lead professional at the centre.

319 Pers Comm: Ms Robyn Collins, Midwifery Clinical Manager, Family Birth Centre, KEMH.
During its investigations the Committee visited the FBC. A report on the visit can be found in Appendix A. The Committee was also pleased to receive a letter from the FBC\(^{320}\) which stated that -

> negotiations [had begun] with the birth centre midwives, general practitioners, consumer representatives and hospital executive to look at the vision of the centre.

The letter outlined a decision "to look at a five year business plan incorporating a greater community focus" and stated that the FBC is considering a model which "would provide collaborative care between Family Birth Centre midwives and general practitioners".

The Committee feels that the FBC has the opportunity to be the focus for local maternity services and the Committee supports the move by the centre to look at cooperation with GPs.

**Policies and protocols**

The policies and protocols for the FBC are thoroughly documented in the Family Birth Centre Manual.\(^{321}\)

**Pain relief in labour**

In the FBC, medications, including local anaesthesia and pain relief are available if needed. Epidural anaesthesia is not available. In 1993-1994, the majority of women (73.7\%) used no pharmaceutical analgesia. Women are welcome to use Transcutaneous Electrical Nerve Stimulation (TENS).

**Discharge**

Women may stay at the FBC for up to 24 hours after the baby's birth but many go home sooner. In 1993-1994, the average length of postpartum stay was 15.8 hours.

**Continuity of care**

The Committee heard that often midwives from the FBC cannot go with women who are transferred and continue their care in the traditional labour ward.

> The initial intention of the FBC was to provide women with continuity of midwife care but as the demand for the centre has increased, the service has become more fragmented. Whilst the philosophy remains women centred, in practice each woman may see a large number of midwives during her pregnancy. Additionally her follow-up care will be by a separate group of midwives who provided domiciliary care for patients discharged from the main hospital as well as from the FBC.\(^{322}\)

The Committee hopes this issue will be addressed in the FBC's five year plan.

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320 Ms Robyn Collins, Midwifery Clinical Manager, Family Birth Centre, KEMH. Correspondence to the Committee, 12 July 1995.


322 Submission 41 - Mrs Sue Terry.
Strategies to enhance continuity of care for women attending the FBC, such as specific case load allocation is currently being debated where FBC midwives may complete a cycle of care for women attending the centre by home visiting in the postnatal period. Currently this care is given by the KEMH domiciliary midwives.323

**Recommendation:**

King Edward Memorial Hospital for Women should examine the change to the Nurses (ANF-WA Public Sector Consolidated) Award at Swan District Hospital that allows nurses to work beyond the end of their shift in order to maintain continuity of care for the patient.

Hundley, *et al.* (1994)324 examined whether intrapartum care and delivery of low-risk women in a midwife managed delivery unit differs from that in a consultant led labour ward. They concluded that "midwife managed care is as safe as the standard consultant led care". They noted a low-level of intervention among women allocated to the midwife unit and said "this alternative is the more effective option for women at low-risk". However, the high rate of transfer (54%) to consultant led care "shows that antenatal criteria are unable to determine who will remain at low-risk throughout pregnancy and labour".

### 5.4 DOMINO BIRTH

Domino stands for "Domiciliary in and out". Ms Rose Halton (26.4.95) from the Birth Place Support Group told the Committee that -

> [the Domino scheme] is an excellent idea, because it gives women access to midwives. Women would have a much better experience when going to hospital with their own midwife. Under the Domino scheme, when a woman goes into labour she contacts her midwife who then cares for that woman at home. If a need to transfer early arises, of course that woman would transfer as is appropriate to do so ... It would give women a lot of what they have been asking for. For consumers to be able to birth in hospital after labouring at home and then be able to go home two to four hours after birth with their midwife would be a good compromise.

> The birth consumers would like to see the Domino scheme extended so that if all is going well, women could birth at home and have followup care at home. The Domino scheme should be offered to women who want to birth at home so that if they need transfer to hospital, there is not a sense of failure which is sometimes put out by hospital personnel and the community.

The Mandurah Birth Centre model will allow women to have a Domino birth.

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323 Supplement to Submission 41 - Ms J Caroline Wilson, Coordinator of Clinical Nursing, KEMH. Correspondence to the Committee, 26 June 1995.


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5.5 HOMEBIRTH

Homebirth is based upon the conception of pregnancy and delivery as natural physiological processes. The basic assumption is that it is normal for a woman’s body to do the work of labor and delivery. Moreover, emphasis is placed on the importance of a relaxed and familiar setting, preferably the home.\textsuperscript{325}

5.5.1 Statistics

In 1993, there were 102 planned homebirths (0.4\% of total births) in Western Australia\textsuperscript{326} (further home birth statistics are in Chapter Three, Section 3.6.1). Women who plan to give birth at home in Australia come from different backgrounds and beliefs including both unconventional and more traditional.\textsuperscript{327}

The National Health and Medical Research Council (NHMRC)\textsuperscript{328} -

acknowledges that while less than 1\% of Australian women choose home birth, their right to choose should be respected and the highest possible standard of service should be available to them. At the same time the Council acknowledges the position of the RACOG and its stated policy that it does not accept the premise that homebirths are a safe alternative, nor does it support the concept of midwives operating independently of medical and/or hospital services.

However, in the NHMRC’s statement, the RACOG does acknowledge -

the right of women to choose to give birth at home and ... it has a clear responsibility to support and develop measures that will ensure, as far as possible, maximum safety in these circumstances.

5.5.2 Appropriate Care

According to the NHMRC,\textsuperscript{329} women who choose a homebirth -

should have access to an integrated team of appropriately trained health professionals with adequate resources. This team should include both community based, (e.g. registered midwife and/or general practitioner) and hospital based, (e.g. obstetrician and paediatrician) personnel.
The Task Forces of New South Wales, Western Australia and Victoria agree that the appropriate homebirth attendant should be either an obstetrician, a general practitioner or an accredited independent practising midwife. There is a strong recommendation that appropriate birth attendants should be accredited to hospitals to update their skills and be subject to peer review.\textsuperscript{330}

The Committee heard that homebirth clients of midwives in private practice (MIPPs) in Perth have an initial appointment with a doctor because midwives are not allowed to order blood tests. Women are then cared for by MIPPs for the remainder of their antenatal care, delivery and postnatal care.

### 5.5.3 Attitudes and Beliefs

According to Odent (1991)\textsuperscript{331} -

> the dominant beliefs regarding home birth are the same everywhere in the industrialised (sic) world (except the Netherlands) and easy to summarise: home birth is dangerous and whenever a pregnant woman mentions home birth in front of her doctor ... the most common reaction is "It is a return to the past." "What will you do if ... ?" The current medical attitude is deeply entrenched ... very few doctors ... mention that birth in a familiar place might be a way to avoid complications.

Odent\textsuperscript{332} recommended that the best way to challenge current beliefs was to look at statistics from the Netherlands.

The Netherlands is the only industrialised (sic) country where one third of all births happen at home ... the only country where they can reconcile a perinatal mortality rate lower than 10 per 1000, a maternity mortality rate lower than 1 per 10,000, and a rate of caesarean section around 6%.

### 5.5.4 Safety

The West Australia Faculty of the Royal Australian College of General Practitioners\textsuperscript{333} in its Policy 39 on Domiciliary Obstetrics states -

> Council sees that there is a greater risk to both mother and baby in domiciliary obstetrics than in hospital deliveries.

A study of planned home and hospital births in Western Australia from 1981-1987 found that planned homebirths in WA appear to be associated with less overall maternal and neonatal morbidity and less intervention than hospital births.\textsuperscript{334}

\textsuperscript{330} Child A. 1990; pp 637-639.
\textsuperscript{331} Odent M. \textit{Planned Home Birth in Industrialized Countries}. WHO Regional Office for Europe, Copenhagen 1991.
\textsuperscript{332} \textit{ibid}. p 8.
\textsuperscript{333} Royal Australian College of General Practitioners (WA Faculty). \textit{Policy 39 on Domiciliary Obstetrics}. September 1984.
A study of homebirths in South Australia concluded that the overall perinatal mortality is five times greater for home births than for hospital births\(^\text{335}\) and "this may have been associated with the process of care or place of delivery" while a Western Australian epidemiological study concluded that perinatal mortality is not linked to the place of birth.\(^\text{336}\)

The results of the Farm Study\(^\text{337}\) conducted in the United States -

suggest that, for relatively low-risk pregnancies, home birth with attendance by lay midwives is not necessarily less safe than conventional delivery.

A comparison of women who planned homebirths with matched women who birthed in hospital, showed higher numbers of normal births and lower numbers of complications, analgesia, need for infant resuscitation and birth trauma in the homebirth group.\(^\text{338}\)

**5.5.5 Transfers**

The study of WA births (1981-1987) showed that one in four women who planned to have a homebirth were transferred to hospital. Most transfers occurred during the first stage of labour and were mainly primiparous women. The most common reason for transfer was failure to progress in the first stage of labour. The AMA Policy Statement\(^\text{339}\) recommends that all public maternity hospitals should develop and implement guidelines for dealing with transfers. The NHMRC\(^\text{340}\) also recommends that -

in the event of a transfer to hospital the highest standard of care should be provided; there is no place for punitive attitudes towards women who have planned home births, or their carers.

According to Child (1990)\(^\text{341}\) -

a patient planning a homebirth should make a provisional booking at the hospital to which the birth attendant is accredited. [This] should logically help to expedite the transfer process.

**5.6 HOSPITAL CARE**
The *Survey for Mothers*\textsuperscript{342} found that approximately 14\% of women reported attending a clinic in a public hospital for antenatal care.

The Committee heard from Dr Hamish McGlashan (16.2.95) that at Osborne Park Hospital there is a team of GPs, midwives and obstetricians. The obstetrician is the head of the team whose job it is to oversee the general standards under which other people work. "Many people would see that as that as a disadvantage in that it lacks personal support or individual care." Osborne Park is a government hospital staffed by sessional obstetricians who do not receive a fee for service. Registrars on rotation from KEMH and three residents training for general obstetrics are there for six months at a time. The hospital runs four antenatal clinics per week. Most antenatal care is shared with local GPs. GPs have access to the hospital but not many attend patients for delivery.

Hospital care is addressed in other sections of the report.

### 5.7 SPECIALIST CARE

The *Survey for Mothers*\textsuperscript{343} found that over one third of respondents (39.6\%) from the metropolitan area and 16.8\% of respondents from the country received antenatal care from a specialist obstetrician. The survey also found that a greater proportion of women attended a private obstetrician for the antenatal care of their first child than did for the birth of subsequent children.

Specialist care is addressed in other sections of the report.

### 5.8 CONTINUITY OF CARE

In all the models of care examined it was apparent that continuity of care was a vital component and the Committee heard from many witnesses who stressed the importance of continuity of care.

One of the major areas of discontinuity of care in Australia today is the lack of systematic integration between hospital, community and GP services.\textsuperscript{344}

Work needs to be done in terms of linking midwives to GP practices so that women enjoy continuity of service from a limited number of providers ... Integration ... between hospital based services and child health community based services is also required.\textsuperscript{345}

Ms Rose Halton (26.4.95) told the Committee that -

\textsuperscript{342} Gilles, et al. 1995; p 7.

\textsuperscript{343} ibid. p 7.

\textsuperscript{344} Submission 41 - Mrs Sue Terry.

\textsuperscript{345} ibid.
continuity of care is a very important issue for women to retain control during birthing ... the main problem with our maternity services is the lack of continuity of care ... The more people involved in a particular case, the more likely there is to be miscommunication.

The Committee heard from Ms Joan Greenwood (8.8.94) that -

women now want more continuity of care so they do not see a different person at each visit to the clinic or they did not meet someone in labour whom they had never met before. One of the most irritating things is for women to have to repeat the same story to a new professional every time. We would have liked a named midwife so that the women knew the name of only one person ... that is not possible .. The best we can achieve is to have a small group of half a dozen or so who will move to where the women are.

The Committee heard that there are sometimes difficulties providing continuity of care for women who are transferred out of the FBC. Midwives from the centre can accompany their clients to the hospital wards and assist with the delivery, if they are not required at the FBC. MIPPs who are accredited to the FBC can also accompany their clients. However, they can only act as a support person in the hospital ward because they do not have hospital accreditation at KEMH.

Recommendation

Midwives in private practice who have accreditation at the Family Birth Centre should now be accredited to the hospital delivery suite at King Edward Memorial Hospital for Women in order to improve continuity of care with the Family Birth Centre.

5.8.1 Examples of Alternative Work Arrangements

One of problems for nursing staff who care for maternity patients in hospital is that staff have to change shifts. The Committee heard that at Swan District Hospital there had been an amendment to the Nurses (ANF - WA Public Sector) Award which allowed staff to remain with a patient and offer continuity of care.

Nurses under this appendix shall have no fixed hours of duty. The minimum number of hours to be worked, however, shall not be less than an average of 152 hours within a work cycle not exceeding 28 days.346

At the Mandurah Birth Centre, a case management scheme had been introduced. Midwives are allocated clients by the month of delivery, e.g. Midwife One will be allocated all the clients who are due in June and Midwife Two will care for all the clients due in July. There are currently three midwives at the centre. Therefore, they are only on call for deliveries for one month out of every three.

Recommendation:

Other hospitals in Western Australia should consider the action taken by Swan District Hospital and the Peel Health Services to allow midwives to work longer shifts where necessary to ensure continuity of care with patients.

Recommendation:

Strategies must be developed by all hospitals and birthing units to improve continuity of care and carer through the antenatal period, during labour and through the postnatal period. These strategies should include such things as birth plans, familiarisation with staff in various parts of the hospital or in the unit, staff rotation through different wards of the hospital, development of alternative work arrangements, availability of a companion in labour, case loads for staff, and case reviews. Details of some of these strategies are addressed in other recommendations.

5.8.2 Staff Rotation

The Committee heard that staff at King Edward Memorial Hospital for Women were allocated to particular wards and did not rotate. Dr Harry Cohen (16.2.95) told the Committee that there are good reasons for not rotating staff.

The delivery ward is the most dangerous place in the hospital in terms of things that can go wrong or happen suddenly, and we have always felt we need a core of experienced midwives in the labour ward ... we understand that everybody has to learn, but not at the expense of having a core of senior people who stay there, at least for some years.

However, the Committee has recently been informed that -

commenc ing in January 1996, rotation of Level 1 midwives through antenatal, postnatal wards and the delivery ward will occur. Initially 12 positions will commence continuous rotation.\(^{347}\)

At Woodside Maternity Hospital, staff rotate through the different areas of the hospital on a roster. Therefore, there is the possibility that a midwife will see the same patient antenatally, during delivery and postnatally.

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\(^{347}\) Supplement to Submission 41 - Ms J Caroline Wilson, Coordinator of Clinical Nursing, KEMH. Correspondence to the Committee, 26 June 1995.
Recommendation:

The Committee endorses the new direction at King Edward Memorial Hospital for Women to allow midwives to rotate through antenatal, labour and delivery, and postnatal areas.

5.8.3 Personal Maternity Records (Case Notes)

Mrs Sue Terry and other witnesses suggested that women should carry their own maternity records. Ms Joan Greenwood (8.8.94) was in favour of a woman carrying around her own records and that she should bring them with her to the professional when she goes for care.

During his recent visit to the Rosie Maternity Hospital in Cambridge, England, the Hon. Ian Taylor was told that women should have the right to carry their own case notes. This allows them to have more control over what happens to them and results in greater patient satisfaction.

This strategy has been discussed previously in Chapter Two, Section 2.3.5.

Recommendation:

Pregnant women should be encouraged and allowed to carry their own maternity records.

5.8.4 Birth Plans

If a woman chooses to have a birth plan it should be written down, discussed and agreed to with her health professional and put in her records. Ms Joan Greenwood (8.8.94) stated "it would be available for whomever is looking after the woman - one professional cannot always be there the whole time".

The Birth Place Support Group provides information and advises women about birthing plans. Ms Sandra Hudson (26.4.95) said that "there seems to be an increase in respect by midwives and hospital staff for birth plans".

There can be no one answer which will suit every woman - but each woman should have the right to choose what happens to her - including the right to put in writing her requirement for a certain course of action.

The Committee heard that a number of hospitals such as Rockingham/Kwinana District Hospital, encourage their patients or clients to produce birth plans.

348 Submission 41 - Mrs Sue Terry.

349 Submission 61 - Ms Judith Bowling.
5.9 POSTNATAL CARE

The NHMRC’s *Draft Report on Options for Effective Care in Childbirth* stated that -

> the postpartum period is often the time when women feel abandoned by their caregivers. This is a period when there is an important role for the midwife and the general practitioner. It should also be a time when specialist obstetricians encourage participation by these two other caregivers for their patients.\(^{350}\)

5.9.1 Hospital Care

A number of witnesses discussed the importance of allowing women to debrief their birth experiences. In her submission, Linda Rawlings states that she encourages women to speak about their experience of childbirth without any medical or abstract references. This can be “incredibly liberating”.\(^{351}\) The Committee believes that this is particularly important for women who have had intervention such as an operative delivery because research indicates that there is a link between intervention in childbirth and postnatal depression.

**Recommendation:**

*Before discharge from a hospital or birthing unit, women must be given the opportunity to have a debriefing session with the midwife who attended their delivery so that they can talk about their birth experience. This is particularly important for women who have had intervention such as an operative delivery because research indicates that there is a link between intervention in childbirth and postnatal depression.*

5.9.2 Early Discharge Programs (EDPs)

The Committee recognised that continuity of care into the postnatal period and after discharge are important especially for mothers who have had intervention. Continuity of care should involve very close liaison between community and child health nurses and the hospital midwives.

In 1989-1990, a pilot early discharge program for new mothers and babies was undertaken at four metropolitan non-teaching hospitals. The program was -

> a new service offering an additional choice to women, and included home-based care by midwives from the time of discharge from hospital up to the tenth postnatal day.\(^{352}\)

The study found that the program was well received by staff and clients. It was also noted that -

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\(^{351}\) Submission 15 - Ms Linda Rawlings.

as the lengths of stay were declining steadily anyway, without the EDP, then if the main aim of the EDP is financial savings there is going to be a diminishing advantage over time.\textsuperscript{353}

The study also commented that the EDP -

introduces yet another care provider for mothers who already encounter several different groups of providers ... the preference for continuity of care by the same providers is often expressed by women ... Perhaps we should be more creative about alternative models of care.\textsuperscript{354}

Ms Mary Cameron, Nursing Administrator at Woodside Maternity Hospital, briefed the Committee that the hospital has an Early Discharge Program. However, women have the option to remain in the hospital until they are ready to leave. Ms Cameron said there is growing concern about early discharge and its effect upon the establishment of successful and continued breastfeeding.

The NHMRC’s \textit{Draft Report on Options for Effective Care in Childbirth}\textsuperscript{355} stated -

we note with some dismay that there has been a trend to reduce the length of stay as a simple cost saving or shifting exercise. If there is a substantial move to reduce the latter, we urge that the monies be re-invested in the provision of postnatal care in different settings. Hospital care should not be reduced until adequate domiciliary care has been implemented.

The Committee shares the NHMRC’s concern that money saved by hospitals through an EDP should be used to provide adequate followup and support programs. There is further discussion of this issue in Chapter Thirteen, Section 13.2.2.

\begin{center}
\textbf{Recommendation:}
\end{center}

Money saved by a hospital through an Early Discharge Program must be reallocated to provide adequate followup programs for postnatal patients such as postnatal domiciliary care programs.

\section*{5.9.3 Postnatal Domiciliary Care Programs (PDCPs).}

In 1991, the National Health and Medical Research Council published the \textit{Principles of operation of postnatal domiciliary care programs}.\textsuperscript{356} The PDCP, by provision of daily midwifery home-visits during the postpartum period, enables healthy women, with their babies, to be discharged from hospital 24-48 hours after giving birth.

The Committee heard that a number of hospitals in Western Australia provide a domiciliary service to maternity patients. Some hospitals have particular midwives who have a domiciliary

\begin{footnotesize}
\begin{tabular}{ll}
\textsuperscript{353} & \textit{ibid.} p 36. \\
\textsuperscript{354} & \textit{ibid.} p 35. \\
\textsuperscript{355} & National Health and Medical Research Council. \textit{Draft report on options for effective care in childbirth} 1994; p 48. \\
\end{tabular}
\end{footnotesize}
role and who may not have met the patient during their stay in hospital or would not have delivered the patient's baby.

In 1994, the King Edward Memorial Hospital for Women reported an increase in its domiciliary service, where patients living within a 40 kilometre radius of the hospital are visited in their homes by midwives after they leave hospital to ensure they are progressing well. The service enables women to return to their homes to be with their families and to ensure that they receive the best clinical care possible.  

The Committee noted that at Osborne Park Hospital, 80% of mothers, who have normal deliveries were discharged home on day 3 post delivery and were seen by midwives under the Early Discharge Program. There was a total of 4,273 domiciliary visits "reflecting a reduced average length of stay for obstetric patients, i.e. 3.11 compared to 3.36 for the previous financial year".  

At Woodside Maternity Hospital, hospital midwives will visit patients if they live close to the hospital. If the midwife who delivered the patient's baby is on duty, the hospital will try to arrange for them to see the patient.

The models of care at the Mandurah Birth Centre ensures that the midwife who provides postnatal domiciliary care has also cared for the patient throughout her pregnancy and delivery.

At the Swan District Hospital Birth Centre, low-risk women have the option of postnatal care at the centre for up to 24 hours followed by domiciliary care by Birth Centre midwives.

In 1993, a Victorian working party examined the issue of earlier discharge and identified some factors as critical to effective service delivery. These included -

1. domiciliary postnatal care is available to all women and infants who require it, particularly those discharged prior to day five after birth;

2. decisions about discharge and the need for domiciliary care are based on a careful assessment of the health of mothers and infants, the availability of family and social support and the knowledge and confidence of mothers in caring for new born infants;

3. domiciliary postnatal services are provided by midwives with current skills in the care of mothers and newborn infants and skills in community/home nursing;

4. continuity of care is facilitated by protocols for the involvement of, and referral to, general practitioners, maternal and child health services and other support services available in the community.

5.9.4 Postnatal Education

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Postnatal groups provide women with the opportunity to share their birth experiences and to obtain support during the first few months after the birth of a baby which have been identified as very stressful for women.

Many hospitals offer postnatal classes. King Edward Memorial Hospital for Women conducts a range of postnatal classes. Postnatal reunions are held at some hospitals as an informal gathering for new parents. Postnatal care and support is also available through community groups.

In 1993, the Health Department of Western Australia produced the *Postnatal Parenting Package*, a 6-7 session program which has a number of objectives.

At the conclusion of the course, participants should be able to -

- demonstrate levels of confidence and satisfaction with motherhood/fatherhood and infant care;
- have realistic expectations of the parenting role and infant care;
- discuss expectations of their infant's behaviour consistent with developmental age;
- demonstrate awareness of community resources which are available to help with different aspects of the parenting role;
- establish informal support networks with other participants which will continue after the completion of the postnatal parenting program.  

The package can be adapted and presenters can supplement the program with other information.

**Debriefing**

As mentioned previously, it is important to give women the opportunity to debrief their birth experiences.

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360 Health Department of Western Australia. *Postnatal Parenting Package for Community Nurses (Child Health)*. Health Promotion Services Branch. 1993.
**Recommendation:**

Women must be encouraged to attend postnatal sessions after they leave hospital and to take the opportunity to debrief their birth experience. This is particularly important for women who have had intervention such as an operative delivery.

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### 5.10 FUNDING

#### 5.10.1 Alternative Birthing Service Program

The Alternative Birthing Services Program (ABSP), commenced in 1989/90, aims to:

- promote greater choice in birthing services in the public health system and to provide an incentive to States and Territories to establish low intervention birthing services managed primarily by midwives;
- allow States and Territories the opportunity to trial midwife managed models of service which may become part of the standard range of services, through the provision of incentive funding to the States and Territories;
- contribute to the establishment of services which are: midwife based; recognise that pregnancy and childbirth are, in the majority of cases, normal life events requiring minimal intervention; involve women as active partners; and provide continuity of care.

Implementation of the program will be guided by a philosophy of care which emphasises the role of the midwife as primary care giver and recognises that pregnancy and childbirth are in the majority of cases normal life events requiring minimal intervention.

**Funding allocation**

During the first phase of the program, from 1989/90-1992/93, $6.4 million was allocated as incentive funding. The Commonwealth Budget provided an allocation of $8.9 million over four years (1993/94-1996/97) for the second phase of the program.

The anticipated expenditure and proposed financial plan for Western Australia under the second phase of the program are shown in Tables 26 and 27.

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363 Information provided to the Committee by the Women's Health Portfolio Manager, State Health Purchasing Authority, Health Department of Western Australia.
### Table 26: ANTICIPATED EXPENDITURE, ALTERNATIVE BIRTHING SERVICES PROGRAM 1994/95 - 1996/97

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>1994/95 $000</th>
<th>1995/96 $000</th>
<th>1996/97 $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthplace Support Group</td>
<td>$13.6</td>
<td>$22.6</td>
<td>$27.6</td>
</tr>
<tr>
<td>Swan District Hospital</td>
<td>$29.5</td>
<td>$108.5</td>
<td>$102.6</td>
</tr>
<tr>
<td></td>
<td>$20.7 c/f</td>
<td>($+20.7)</td>
<td>$129.2</td>
</tr>
<tr>
<td>Mandurah/Murray Hospital</td>
<td>$25.8</td>
<td>$285.0</td>
<td>$282.0</td>
</tr>
<tr>
<td>Halls Creek Community Midwifery</td>
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<td>$51.7</td>
<td>$52.6</td>
</tr>
<tr>
<td></td>
<td>$25.2 c/f</td>
<td>($+25.2)</td>
<td>$76.9</td>
</tr>
<tr>
<td>Rockingham Kwinana Hospital</td>
<td>$30.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Multicultural Women's Health Centre (Fremantle)</td>
<td>-</td>
<td>$220.0</td>
<td>$220.0</td>
</tr>
<tr>
<td>Woodside Hospital</td>
<td>-</td>
<td>$42.0</td>
<td>-</td>
</tr>
<tr>
<td>State Evaluation</td>
<td>-</td>
<td>$10.0</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$98.9</strong></td>
<td><strong>$785.7</strong></td>
<td><strong>$684.8</strong></td>
</tr>
</tbody>
</table>

SOURCE: Women's Health Portfolio Manager, Health Department of Western Australia.

### Table 27: PROPOSED FINANCIAL PLAN, ALTERNATIVE BIRTHING SERVICES PROGRAM 1994/95 - 1996/97

<table>
<thead>
<tr>
<th></th>
<th>1994/95 $000</th>
<th>1995/96 $000</th>
<th>1996/97 $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds carried forward by Cm'wlth</td>
<td>$674.0</td>
<td>$666.5</td>
<td>$384.2 (?)</td>
</tr>
<tr>
<td>+ Current year allocation</td>
<td>$228.6</td>
<td>$228.6</td>
<td>$247.0 (?)</td>
</tr>
<tr>
<td>Total funds avail.from Cm'wlth</td>
<td>$902.6</td>
<td>$895.2</td>
<td>$631.2 (?)</td>
</tr>
<tr>
<td>+ Cash on hand in trust account</td>
<td>$137.5</td>
<td>$274.7</td>
<td>?</td>
</tr>
<tr>
<td>=Total funds available</td>
<td>$1040.1</td>
<td>$1169.9</td>
<td>$631.2 (?)</td>
</tr>
<tr>
<td>Less projected expenditure</td>
<td>$98.9</td>
<td>$785.7</td>
<td>$684.8 (?)</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td><strong>$941.2</strong></td>
<td><strong>$384.2</strong></td>
<td><strong>(-$53.6)(?)</strong></td>
</tr>
</tbody>
</table>

SOURCE: Women's Health Portfolio Manager, Health Department of Western Australia.
5.10.2 Funded Western Australian Projects

A number of Western Australian health services and groups have applied for and received funding through the Alternative Birthing Services Program. These include -

Derby Family Birthing Unit

One-off funding of $109,000 was provided through the program for a family birthing unit in the Derby Regional Hospital, completed in 1992/93. The unit continues to operate using existing hospital staffing and funds.

Halls Creek Community Midwifery Project

Under this continuing project a midwife is to be employed to provide outreach antenatal and postnatal care to Aboriginal women who will usually travel to Derby Hospital for the birth of their babies.

The following four projects were allocated funds from the 1994/95 budget -

Mandurah Alternative Birthing Service

Specially appointed midwives who have a community focus will provide antenatal care, delivery in the hospital family birthing suite and postnatal care, in a shared care program with general practitioners.

Swan District Hospital Alternative Birthing Service

Commencement of the family birth centre at the Hospital using a hospital midwifery team model of care with GP and obstetrician support.

Birthplace Support Group: Fremantle Resource, Information and Referral Centre

A midwife operated information and resource centre open one day per week, offering pre-conception counselling and referral, prenatal classes, support during pregnancy and postnatal advice and support.

Rockingham/Kwinana Health Service

Capital funding for renovations to establish a birth centre at Rockingham Hospital.

5.10.3 Funding Proposals

The Committee received information from the Multicultural Women's Health Centre about a proposal to the ABSP to fund a project to address antenatal education for women with special needs, to provide home and Domino births; to provide information and to employ bilingual or bicultural workers. The Multicultural Women's Health Centre intends to work with Woodside Maternity Hospital and midwives in private practice. Multicultural women's needs are also addressed in Chapter Twelve, Section 12.2.

364 Information provided to the Committee by Ms Marian Lin, State Health Purchasing Authority, Health Department of Western Australia.
The Committee also received a copy of a proposal for funding from the Silver Chain Nursing Association, Northern Metropolitan Region for a Northern Metropolitan Community Midwifery Service. The proposed service would include -

a team of accredited midwives who will provide antenatal and postnatal care in a community (non hospital) setting, and will be available to attend the birth in either a home or hospital setting. Personal care and domestic support services will be available during the postnatal period for the women who choose a homebirth.

**Recommendation:**

The Committee would like to see utilisation of all the money which is available through the Alternative Birthing Services Program.

**Recommendation:**

The Committee supports the continued provision of funding by the Alternative Birthing Services Program and urges the Commonwealth Department of Human Services and Health to continue to provide funding beyond 1997. The development of programs which will require funding may take a number of years.

**Recommendation:**

A special capital works program should be launched with State and Federal Health Departments and the Lotteries Commission of Western Australia to jointly fund the capital requirements to establish new programs of models of maternity care which emphasise the role of the midwife and the general practitioner in the management of all low-risk pregnancies. The Committee recommends that the capital works requirements of Woodside Maternity Hospital should be given priority funding through such a program.

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365 Silver Chain Nursing Association, Northern Metropolitan Region, Community Care Services. Proposal for funding to the Alternative Birthing Services Program. 28 July 1995.
Recommendation:

Programs which have been funded by the Alternative Birthing Services Program and found, after evaluation, to have been successful should be examined and implemented in other appropriate locations.

5.11 CONCLUSION

The Committee was very impressed with the range of models of care being developed in Western Australia. Although many are at early stages, there has been extensive consultation with all parties involved and it is reasonable to expect that there will be good outcomes. It is important that the existence of the programs available at various hospitals is widely publicised. Overall the Committee favoured the shared care model. It would like to see midwives and GPs working in close liaison with the opportunity to consult with a supportive obstetrician.

Recommendation:

Shared care between GPs and midwives, with the midwife having the lead role in low-risk deliveries, should be practised more widely in Western Australia. This model facilitates continuity of care and reflects mutual recognition of the skills of both midwives and GP obstetricians in the provision of maternity services.

Recommendation:

The Health Department of Western Australia in consultation with interested parties, must produce a booklet for pregnant women or women of childbearing age and their partners which outlines the different models of maternity care available in Western Australia, and the philosophies and the procedures practised at individual hospitals, birthing units, the Family Birth Centre or during home deliveries. It must include the names of currently practising community midwives, GPs and obstetricians that mothers can approach for information. Divisions of General Practice should be encouraged to be involved with the distribution of the booklet.
RECOMMENDATIONS

Recommendation:
The Family Birth Centre (FBC) midwives must be allowed to consult with a GP obstetrician or relevant medical specialist at the FBC if there are medical indicators which require a medical opinion rather than having a patient transferred over to the labour ward for a medical reason. However, the midwife is the lead professional at the centre.

Recommendation:
King Edward Memorial Hospital for Women should examine the change to the Nurses (ANF-WA Public Sector Consolidated) Award at Swan District Hospital that allows nurses to work beyond the end of their shift in order to maintain continuity of care for the patient.

Recommendation:
Midwives in private practice who have accreditation at the Family Birth Centre should now be accredited to the hospital delivery suite at King Edward Memorial Hospital for Women in order to improve continuity of care with the Family Birth Centre.

Recommendation:
Other hospitals in Western Australia should consider the action taken by Swan District Hospital and the Peel Health Services to allow midwives to work longer shifts where necessary to ensure continuity of care with patients.
Recommendation:

Strategies must be developed by all hospitals and birthing units to improve continuity of care and carer through the antenatal period, during labour and through the postnatal period. These strategies should include such things as birth plans, familiarisation with staff in various parts of the hospital or in the unit, staff rotation through different wards of the hospital, development of alternative work arrangements, availability of a companion in labour, case loads for staff, and case reviews. Details of some of these strategies are addressed in other recommendations.

Recommendation:

The Committee endorses the new direction at King Edward Memorial Hospital for Women to allow midwives to rotate through antenatal, labour and delivery, and postnatal areas.

Recommendation:

Pregnant women should be encouraged and allowed to carry their own maternity records.

Recommendation:

Before discharge from a hospital or birthing unit, women must be given the opportunity to have a debriefing session with the midwife who attended their delivery so that they can talk about their birth experience. This is particularly important for women who have had intervention such as an operative delivery because research indicates that there is a link between intervention in childbirth and postnatal depression.

Recommendation:

Money saved by a hospital through an Early Discharge Program must be reallocated to provide adequate followup programs for postnatal patients such as postnatal domiciliary care programs.
Recommendation:

Women must be encouraged to attend postnatal sessions after they leave hospital and to take the opportunity to debrief their birth experience. This is particularly important for women who have had intervention such as an operative delivery.

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The Committee would like to see utilisation of all the money which is available through the Alternative Birthing Services Program.

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The Committee supports the continued provision of funding by the Alternative Birthing Services Program and urges the Commonwealth Department of Human Services and Health to continue to provide funding beyond 1997. The development of programs which will require funding may take a number of years.

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Programs which have been funded by the Alternative Birthing Services Program and found, after evaluation, to have been successful should be examined and implemented in other appropriate locations.

Recommendation:

Shared care between GPs and midwives, with the midwife having the lead role in low-risk deliveries, should be practised more widely in Western Australia. This model facilitates continuity of care and reflects mutual recognition of the skills of both midwives and GP obstetricians in the provision of maternity services.

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The Health Department of Western Australia in consultation with interested parties, must produce a booklet for pregnant women or women of childbearing age and their partners which outlines the different models of maternity care available in Western Australia, and the philosophies and the procedures practised at individual hospitals, birthing units, the Family Birth Centre or during home deliveries. It must include the names of currently practising community midwives, GPs and obstetricians that mothers can approach for information. Divisions of General Practice should be encouraged to be involved with the distribution of the booklet.
CHAPTER SIX

POSTNATAL DEPRESSION

6.1 INTRODUCTION

The Committee views postnatal depression very seriously and therefore, a specific chapter has been allocated to the topic.

Ms Sherryl Pope, Senior Clinical Psychologist at King Edward Memorial Hospital for Women (KEMH) (8.2.95), described different postnatal emotional problems to the Committee. The most common emotional problem after childbirth is the "Baby Blues". This affects up to 80% of women and is usually evident 3-5 days after delivery. At the extreme is a psychotic condition "puerperal psychosis" which affects 0.1% to 0.2% of women within the first two to four weeks after delivery. Postnatal depression refers to a non-psychotic condition that is diagnosed at any time during the first 12 months postpartum and emerges in the first few weeks after delivery. The characteristics of postnatal depression are cited by Holden (1994) as -

- tearfulness, despondency, feelings of inadequacy and inability to cope, particularly with the baby
- Guilt and self-reproach over not loving or caring enough for the baby
- excessive anxiety over the baby which was not justified by the baby's health
- Unusual irritability was common, adding to feelings of guilt
- impaired concentration and memory, and undue fatigue and ready exhaustion were frequent, so that mothers could barely deal with their babies, let alone look after the rest of the family and cope with housework and shopping
- anorexia was present with remarkable consistence, and sleep disturbances, over and above that inevitable with a new baby, were reported by a third of the patients.

Astbury, et al. (1994) who found that 15.4% of recent mothers surveyed were found to have postnatal depression.

The Committee heard from Ms Sherryl Pope (8.2.95) that -

the rate of postnatal depression in Australia and overseas is probably between 15 and 20 per cent. I consider that to be an underestimate because all it looks at is cases of clinical depression that have been diagnosed by some means, either by research studies or from women who come forward. It does not take into account the huge grey area of women who may be mildly depressed or who would not recognise what is happening to them and therefore, do not ever come forward for treatment.

In Western Australia, it is estimated that up to 5000 women a year or 15 to 20 per cent of childbearing women could be affected by postnatal depression.

The Committee heard evidence and reviewed research which links intervention in childbirth with postnatal depression.


The *Survey for Mothers* asked women to make suggestions for improvement in postnatal care. Of all the women who responded to the question, 17% requested emotional support. Eight women (2%) specifically mentioned postnatal depression and their need for "more support from the system". Of these women, four had emergency intervention (two caesarean sections and two forceps), two had an elective caesarean section and two had a normal vaginal delivery.

### 6.2 INCIDENCE FOLLOWING INTERVENTION

Boyce and Todd (1992) found that when compared with women having a spontaneous vaginal delivery or forceps delivery, women who had an emergency caesarean section had more than six times the risk of developing postnatal depression three months postpartum. Astbury, *et al.* 1994 also noted that women who scored as potentially depressed according to the Edinburgh Postnatal Depression Scale (EPDS) were more likely to have had an operative delivery and obstetric procedures than those women who did not score as being depressed. They found that factors associated with increased odds of depression included having a first child when the mother is over 34 years of age, assisted delivery (caesarean section, forceps and vacuum), bottle feeding, dissatisfaction with antenatal care, having unwanted people present at the birth; and lacking confidence to look after the baby at the time of leaving the hospital.

### 6.3 PREVENTION AND TREATMENT

The Committee heard that KEMH has been selected by the Commonwealth Government for its role as a teaching centre to develop and establish a statewide strategy to treat women with postnatal depression.

The Committee heard that anxiety disorders should be assessed antenatally and women could then be offered appropriate services throughout pregnancy. Women considered at risk of developing psychological problems in relation to childbirth should be screened and assessed antenatally.

The opportunity to debrief one's birth experience and access to postnatal education may help women to avoid or to recognise signs of postnatal depression.

The National Health and Medical Research Council's (NHMRC) *Draft Report on Options for Effective Care in Childbirth* felt that the postnatal check was an opportunity for an inquiry about a woman's mood and if required referral to support groups or relevant health professionals. A study cited in the NHMRC report showed that -

> Non-directive counselling with specifically trained professionals offering a woman the opportunity to talk about herself and her own needs and feelings independent of the baby has been found to reduce depression in a randomised UK trial.

The Committee heard from Ms Sherryl Pope (8.2.95) that there are almost no services for women with emotional problems, particularly in the case of remote and rural women.

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Women are at risk because they do not know what is occurring, there is no coordination of services in the metropolitan area, there is no inpatient facility for mothers and babies and if women need in-patient management, they are usually separated from their babies which again increases the likelihood of the depression being much more severe.

A respondent to the Survey for Mothers said -

there is a chronic need for some support group or facility available for the treatment of postnatal depression other than a psychiatric hospital ... I was horrified to discover the only support groups available were in the Eastern States.

**Recommendation:**

Women who have had a caesarean section or other operative delivery should be assessed postnatally by their GP or midwife and helped if required to avoid the possibility of developing postnatal depression.

6.4 RESEARCH

The Committee heard from Ms Pope (8.2.95) that she is conducting research in the area of postnatal depression. She is trying to determine what factors contribute to the development of postnatal depression. The findings of the research could be used to develop an antenatal screening program to find women who may be at risk of developing significant postnatal problems.

**Recommendation:**

Research shows there is a link between postnatal depression and intervention in childbirth and further research should be conducted into the extent of postnatal depression in the community.

---


RECOMMENDATIONS

Recommendation:

Women who have had a caesarean section or other operative delivery should be assessed postnatally by their GP or midwife and helped if required to avoid the possibility of developing postnatal depression.

Recommendation:

Research shows there is a link between postnatal depression and intervention in childbirth and further research should be conducted into the extent of postnatal depression in the community.
CHAPTER SEVEN

PROFESSIONAL ROLES

7.1 INTRODUCTION

The Committee heard that there is a crisis looming in the area of maternity services with reductions in numbers of professionals and uncertainty about professionals roles. It was suggested that this is an appropriate time to examine the roles of midwives, GP obstetricians and specialist obstetricians, and to determine if there could be better use made of resources.

A number of witnesses explained to the Committee that midwives, GP obstetricians and specialist obstetricians all have important roles to play and that they need to work closely and cooperate with each other.

In her submission, Mrs Sue Terry raised the concept of the most appropriate "lead professional" being predicted by the health needs of the pregnant woman.

For the healthy woman with a normal pregnancy, the lead professional should be a midwife who will refer to the medical practitioner as appropriate. For women with some minor health problems or some concerns with the pregnancy, the lead professional should be the GP (Dip Obstetrics) in conjunction with the midwife. For women with health problems and an at-risk pregnancy, the lead professional will be the obstetrician who will call on other medical specialists as indicated.375

Dr Katrina Alexander (9.2.95) told the Committee -

I see the GP, the specialist and the midwife as a team, none of whom can work without the other ... It is difficult to try to have a team, without having people who are used to working together.

Dr Myra Brown (16.2.95) said -

the potential for complication in apparent low-risk cases underlies the fundamental importance of the close relationship between midwives, general practitioners and specialist obstetricians.

Dr Graham Smith (9.2.95) told the Committee -

they (midwives) have a very important role to play in the management of healthy women with a normal pregnancy. However, there must be some ability to have immediate referral to high levels of professional care.

Dr Peter Richardson (26.4.95) stated that -

you need to get the three key players - general practitioners, midwives and obstetricians - together and you need to try to agree on protocols which allow a safe, and as best you can, in an ongoing event, elimination of high-risk patients who should be delivered in hospital and low-risk patients who can be delivered in birthing units or by general practitioners.

375 Submission 41 - Mrs Sue Terry.
According to the Expert Maternity Group in the United Kingdom -

as midwives take more responsibility for caring for women with uncomplicated pregnancies, obstetricians should have more time to care for women whose pregnancies are complicated. This should improve the quality of obstetric consultations and also facilitate continuity of carer. 376

7.2 ROLE OF THE MIDWIFE

The Committee was made aware of evidence from witnesses and literature which outlined the importance of midwives in maternity services and the underutilisation of their skills. As Dr Marsden Wagner pointed out, "midwifery has been a legitimate and well established health profession in Europe for hundreds of years". 377

7.2.1 Definition of a Midwife

The International Confederation of Midwives definition, accepted by the World Health Organization and the International Federation of Gynaecology and Obstetrics is as follows -

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

Sphere of Practice

She [he] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and post-partum period, to conduct deliveries on her [his] own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She [he] has an important task in health counselling and education, not only for the mothers, but also within their family and their community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She [he] may practise in hospitals, clinics, health units, domiciliary conditions or in any other service. 378

The Australian College of Midwives Inc. has determined four standards for the practice of midwifery. These are -

**Standard 1 - Professional Responsibility and Accountability.** The midwife achieves responsibility and accountability for her [his] own practice through self-evaluation, takes responsibility for personal professional development and facilitates the education of colleagues and students.

**Standard 2 - Midwifery Practice.** The midwife utilises a problem-solving approach in order to provide comprehensive midwifery care to individuals, families and communities.

**Standard 3 - Health Education.** The midwife provides health education for the mother, family and community as an integral part of midwifery care.

**Standard 4 - Legislation, Policies and Procedures.** The midwife formulates midwifery care in accordance with legislation, policies and procedures affecting practice.

The Victorian Ministerial Review of Birthing Services *Having a Baby in Victoria* quoted the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Committee) which stated that -

adequately trained midwives can provide a high standard of care for women during an uncomplicated pregnancy and confinement, however ... such care should be part of an integrated obstetric team.

The National Health and Medical Research Council's (NHMRC) *Draft Report on Options for Effective Care in Childbirth* stated that -

midwives have sought and obtained a greater role in provision of care for selected groups of women. This is a trend which is likely and should be encouraged to continue.

The report of the UK Expert Maternity Group, *Changing Childbirth*, proposed that -

a woman with an uncomplicated pregnancy should, if she wishes, be able to book with a midwife as the lead professional for the entire episode of care including delivery in a general hospital.

In addition, the report proposed that -

within 5 years, 75% of women should be cared for in labour by a midwife whom they have come to know during pregnancy.

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Another of the report's action points was that -

the part which a midwife plays in maternity care should make full use of all her skills and knowledge, and reflect the full role for which she has been trained.

The Committee heard from Ms Joan Greenwood (8.8.94) that -

a midwife is trained and educated to support a woman and be with her not necessarily to be doing things all the time ... that is not what doctors are trained to do. They are trained to intervene and to manage.

As stated in Chapter Five, Section 5.10.1, the implementation of the Alternative Birthing Services Program will "be guided by a philosophy of care which emphasises the role of the midwife as primary care giver". 383

The Victorian Ministerial Review of Birthing Services stated that -

the time is ripe for midwives to be given the opportunity to practice as primary care givers according to the accepted international definition and for a collaborative approach to obstetric care to be forged between the medical and midwifery professions. 384

The Committee felt that the skills and professionalism of midwives should be recognised by their medical colleagues and the general community.

**Recommendation:**

Midwives should be encouraged to work in close cooperation with GPs and specialist obstetricians as part of a "shared care" team. The midwife should be the lead professional for those low-risk deliveries.

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7.2.2 Midwife Demographics

**Number**

Over the past few years there has been a gradual decline in the number of midwives registered with the Nurses' Board of Western Australia. In 1991, there were 3,885 registered midwives. 385 Currently, there are 3,726 midwives registered but it is not possible to determine the exact number currently practising. Of these, 380 are members of the Australian College of Midwives Inc. 386 The majority of midwives are salaried employees of hospitals or other government institutions. A small number are self-employed as midwives in private practice. It

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385 Data tabled before the Committee by Mrs Barbara Horner (16.2.95).
386 Submission 69 - Ms Carol Thorogood.
was suggested to the Committee that the reduction in the number of midwives may be related to the financial cost for training to nurses who later wish to return to study to become qualified midwives.

**Age**

As they require a post registration qualification in addition to their general nursing education, the average age of midwives in 1994 was slightly older than for all nurses (41.3 versus 39.9 years). The average age of midwives has increased since 1989 when it was 37.8 years (Table 28).

**Location of employment**

Two thirds of midwives (66.7%) who renewed their registration in 1994, were employed in the Perth metropolitan area. The remainder worked in rural Western Australia (Table 28). Midwives were more likely to work in the country than general nurses (33.3% versus 23.4%).

**Employment status**

Almost half of the midwives (48.4%) who reregistered in 1994 worked full-time and 51.6% worked part-time. Since 1989, there was a 5% decline in the number of midwives who worked full-time (Table 28). Almost three quarters of the midwives (73.4%) worked in the public sector (Table 28).

**Area of nursing**

Thirty five point eight per cent of midwives were working in midwifery, 7.2% in community health and 5.8% in child health nursing (Table 29).

**Training**

Almost half of the midwives (48.4%) who renewed their registration in 1994, gained their initial qualification in Western Australia.

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387 Health Department of Western Australia. *Survey of nurses registered in Western Australia*. 1994; p 11.

388 *ibid.* p 11.
Table 28: CHARACTERISTICS OF THE WA NURSING LABOURFORCE REGISTERED AS MIDWIVES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Persons</td>
<td>2004</td>
<td>2897</td>
<td>3164</td>
<td>3107</td>
<td>2445</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>97.7%</td>
<td>98.1%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>98.3%+</td>
</tr>
<tr>
<td>Male</td>
<td>2.3%</td>
<td>1.9%</td>
<td>1.7%</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Mean Age: (Years)</td>
<td>37.8</td>
<td>38.3</td>
<td>40.4</td>
<td>40.6</td>
<td>41.3</td>
</tr>
<tr>
<td>Place of Initial Qualification:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Western Australia</td>
<td>49.4%</td>
<td>48.7%</td>
<td>49.2%</td>
<td>49.7%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Other Australian States</td>
<td>28.6%</td>
<td>27.4%</td>
<td>26.7%</td>
<td>26.8%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Overseas</td>
<td>22.1%</td>
<td>23.9%</td>
<td>24.1%</td>
<td>23.5%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Nursing Employment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed in Nursing</td>
<td>87.1%</td>
<td>87.1%</td>
<td>88.7%</td>
<td>90.7%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Not Employed in Nursing</td>
<td>12.9%</td>
<td>12.9%</td>
<td>11.3%</td>
<td>9.3%</td>
<td>7.6%</td>
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<tr>
<td>Employment Location:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Perth Metropolitan Area</td>
<td>63.2%</td>
<td>66.3%</td>
<td>68.2%</td>
<td>67.9%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Rural Western Australia</td>
<td>36.8%</td>
<td>29.6%</td>
<td>31.8%</td>
<td>32.1%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Overseas</td>
<td>-</td>
<td>4.1%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Principal Employment Type:</td>
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<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>53.4%</td>
<td>51.2%</td>
<td>48.2%</td>
<td>47.9%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Part-time</td>
<td>35.7%</td>
<td>37.9%</td>
<td>40.7%</td>
<td>52.1%</td>
<td>51.6%</td>
</tr>
<tr>
<td>Casual</td>
<td>10.9%</td>
<td>10.9%</td>
<td>11.1%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employment Sector:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>72.6%</td>
<td>71.6%</td>
<td>74.9%</td>
<td>73.4%</td>
</tr>
<tr>
<td>Private</td>
<td>27.6%</td>
<td>27.4%</td>
<td>28.4%</td>
<td>25.1%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Also Registered as General:</td>
<td>95.8%</td>
<td>97.5%</td>
<td>97.9%</td>
<td>100%</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

* Preliminary data only.
+ This figure was reported as 93.8% in the original document.
Table 29: NUMBER AND PERCENTAGE OF CLINICIAN MIDWIVES IN EACH AGE GROUP EMPLOYED IN SPECIFIC AREAS OF PRACTICE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Midwifery</th>
<th>Community</th>
<th>Child Health</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29 Years</td>
<td>96 (56.1%)</td>
<td>7 (4.1%)</td>
<td>1 (0.6%)</td>
<td>67 (39.2%)</td>
<td>171 (100%)</td>
</tr>
<tr>
<td>30-39 Years</td>
<td>274 (36.6%)</td>
<td>40 (5.4%)</td>
<td>18 (2.4%)</td>
<td>416 (55.6%)</td>
<td>748 (100%)</td>
</tr>
<tr>
<td>40-49 Years</td>
<td>170 (33.1%)</td>
<td>45 (8.8%)</td>
<td>39 (7.6%)</td>
<td>259 (50.5%)</td>
<td>513 (100%)</td>
</tr>
<tr>
<td>50-59 Years</td>
<td>75 (28.4%)</td>
<td>26 (9.9%)</td>
<td>37 (14.0%)</td>
<td>126 (47.7%)</td>
<td>264 (100%)</td>
</tr>
<tr>
<td>60 + Years</td>
<td>2 (6.9%)</td>
<td>6 (20.7%)</td>
<td>5 (17.2%)</td>
<td>16 (55.2%)</td>
<td>29 (100%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>617 (35.8%)</td>
<td>124 (7.2%)</td>
<td>100 (5.8%)</td>
<td>884 (51.2%)</td>
<td>1725 (100%)</td>
</tr>
</tbody>
</table>

SOURCE: Survey of Nurses registered in Western Australia 1994, Health Department of Western Australia

7.2.3 Areas in which Midwives Work

As indicated in the demographics, the majority of Western Australian midwives work in hospitals. Therefore, midwifery practice is largely determined by the midwifery service available at the hospital and by current hospital policies.

Hospital

Tertiary hospital

The Committee was told that at King Edward Memorial Hospital for Women, KEMH, midwifery services are divided into three areas - antenatal care, labour and delivery, and postnatal care. The hospital caters for many high-risk cases and many of the staff become highly specialised. As a result, staff tend not to rotate through the different wards of the hospital and do not get a chance to experience other aspects of maternity services and to offer continuity of care to women. However, from 1 January 1996, rotation of Level 1 midwives through antenatal, postnatal wards and the delivery ward will occur (see Chapter Five, Section 5.8.2). In smaller hospitals, midwives are more likely to experience all areas of maternity services.

Recommendation:

The Committee endorses the new direction by the Director of Nursing at King Edward Memorial Hospital for Women to allow staff to rotate through antenatal, labour and delivery, and postnatal areas.

Peripheral metropolitan hospital

The Committee visited Swan District Hospital and Woodside Maternity Hospital. The reports on the visits are included in Appendix A.
Private hospital

The Committee visited St John of God Hospital, Murdoch. The midwives at the hospital work with specialist obstetricians. The report on the Committee's visit can be found in Appendix A.

The Committee also received a submission from Glengarry Hospital, an 80 bed private hospital situated in the northern suburbs of Perth. The maternity unit consists of 28 beds and averages 1,000 deliveries per year.

Regional hospital

The Committee visited both Kalgoorlie and Bunbury Regional Hospitals. Reports on the Committee's visits are in Appendix A.

At Kalgoorlie Regional Hospital, the midwives have a very strong team approach. The philosophy of the maternity unit is -

{quote}
to provide care and support to pregnant, labouring and nursing mothers, together with their partners in a home-like atmosphere. To achieve this, emphasis will be placed on the importance and advantage of bonding, realising that each mother and her baby are individuals, therefore support and guidance shall be given accordingly.
{quote}

Small country hospital

The Committee visited Collie and Pinjarra (Murray) District Hospitals. In small country hospitals, midwives may be required to work in all areas of maternity services and if the hospital is short staffed they may need to help out in other areas. Therefore, midwives do need to have a general nursing training in addition to their midwifery qualification. The reports on the Committee's visits can be found in Appendix A.

Hospital birth centre

Members of the Committee visited hospital birth centres at Mandurah and Swan District Hospitals. The models of care at each of the centres has been discussed in Chapter Five, Section 5.2. Special working arrangements have been put in place for midwives. Midwives at Mandurah Hospital are allocated cases under a case load management scheme.

Family Birth Centre

The Family Birth Centre has been discussed in detail in Chapter Five, Section 5.3 and a report on the Committee's visit to the centre can be found in Appendix A.

Midwifery in private practice

An independent practising midwife is -

{quote}
a midwife registered with the Nurses' Board of Western Australia, accredited with the Australian College of Midwives Inc. who has notified the Health Department of Western Australia as required under Section 5, Midwifery Regulations (1982). The independent practising midwife
has a private contractual agreement with the woman and works independently of a hospital, community health service or any health-related organisation.\textsuperscript{389}

More recently, the Health (Notification by Midwives) Regulations 1994, under the \textit{Health Act 1911} have stated that -

a midwife is not to enter into private practice as a midwife unless he or she has notified the Executive Director, Public Health of his or her intention to do so in the form of Form I in the Schedule.

The Australian College of Midwives Inc. (ACMI) defines an independently practising midwife as an experienced midwife who -

(a) is registered with the nursing registering authority of the State or Territory in which she/he is practising;

(b) has fulfilled the criteria for accreditation by the Australian College of Midwives Incorporated.\textsuperscript{390}

Dr Dale Evans (9.2.95) told the Committee that -

when you talk about independent midwives or independent practitioners who are not medically trained, you have to increase the level of training because Australian training of midwives is not adequate to allow them to take on that sort of care.

\textbf{7.2.4 Midwife Registration and Accreditation}

\textbf{Registration}

Midwives who practise midwifery in Western Australia must be registered with the Nurses' Board of Western Australia.

\textbf{Australian College of Midwives Inc. (ACMI) accreditation}

There are a number of midwives who practise privately in Western Australia, but there are currently only four midwives accredited to the ACMI in Western Australia. In 1993, the accreditation process was reviewed and new guidelines have been introduced and ratified nationally. The midwife must -

\begin{itemize}
  \item be registered with the nurse registering authority of the State or Territory in which practice is undertaken;
  \item hold a current practising certificate;
  \item provide evidence of midwifery practice within the last five years;
  \item have evidence of current membership of the ACMI;
\end{itemize}

\textsuperscript{389} Moore D and Bray M. \textit{Guidelines for the hospital accreditation and clinical privileges for independent practising midwives in Western Australia.} Health Department of Western Australia, 1992.

\textsuperscript{390} Australian College of Midwives Incorporated. \textit{Accreditation of the independently practising midwife.}
have a minimum of two years post registration midwifery experience which will include practice under the preceptor of an accredited Independent Practising Midwife (IPM) preceptor.  

Mrs Vivien Gee (27.4.95) told the Committee -

there are midwives conducting homebirths who are not accredited. There is nothing in the legislation or the requirement by the Department to say how much experience they should have before they take up their independent practice. However, like any registered midwife, they must work within the codes of practice of the Nurses' Board.

Hospital accreditation of midwives in private practice

In Western Australia, midwives in private practice can be accredited to deliver babies in hospitals. This developed from consumer demand and increased community awareness of the benefits of midwifery care.

Women should have the opportunity to select the birth attendant and birth setting of their choice. Hospital accreditation and granting of clinical privileges to independent practising midwives provides women with the option of having a midwife as a primary carer responsible for pregnancy, labour/delivery and postnatal care, and of delivering in a hospital.

In response to a recommendation of the WA Ministerial Task Force (1990), guidelines were developed so that all hospitals could accredit approved independent practising midwives and increase the choices available to women requiring maternity services.

The Guidelines for the hospital accreditation and clinical privileges for independent practising midwives in Western Australia include how to apply for accreditation, the conditions of appointment and protocols for hospital admission.

In order to be eligible to apply for hospital accreditation and clinical privileges, an independent practising midwife must also be accredited with the ACMI. As at the present time, only four midwives in Western Australia are eligible for hospital accreditation.

Recommendation:

There should be encouragement and opportunity for more midwives to train in order to obtain their accreditation with the Australian College of Midwives Inc, which will in turn allow them to apply for hospital accreditation.

ibid.


Hospitals where midwives in private practice are accredited include Woodside Maternity Hospital, Swan District Hospital, Undercliffe Hospital Complex, Gosnells Family Hospital, and South Perth Community Hospital. The Committee heard recently that the midwives have also been accredited to the Family Birth Centre at King Edward Memorial Hospital for Women. In the next six months they hope to be able to gain accreditation to the hospital itself.

**Recommendation:**

Midwives in private practice who have accreditation at the Family Birth Centre should now be accredited to the hospital delivery suite at King Edward Memorial Hospital for Women in order to improve continuity of care with the Family Birth Centre.

---

### 7.2.5 Remuneration and Refunds for Midwifery Services

#### Hospital staff

The salaries for nurses in government hospitals are as per the Nurses (ANF-WA public sector consolidated) Award and nurses in private hospitals are covered by the Nurses (Private Hospitals) Award.\(^{394}\)

#### Midwives in private practice

The Committee heard that midwives in private practice may charge up to $1600. The fee includes antenatal care, labour and delivery, and postnatal care.

The Committee heard from Ms Bronwyn Key (26.4.95) that -

> a woman does not have the opportunity to see the same midwife throughout her pregnancy to give her the opportunity to feel safe and secure thus maximising the potential of having a normal birth, without paying $1,600.00 ... it is not at all fair, it does not give some women a real choice.

Midwives in private practice are not covered by a Medicare rebate. However, some medical benefit funds cover part of the fees for a homebirth. Therefore, women who choose to be cared for by an independent practising midwife must be treated as private patients. This means that independent midwifery services are restricted to those who can afford them.

Ms Key also told the Committee that -

> there should be a community based midwifery system where regional health authorities employ midwives who can be accessed by women who live in that region.

A scheme where women do not have to pay for a home delivery is discussed in Chapter Five, Section 5.2.5.

---

\(^{394}\) Department of Productivity and Labour Relations, Perth, Western Australia. 5 May 1995.
"Intervention (will) be reduced ... when midwifery care is paid for from the public purse allowing women and their families real choices in childbirth."\textsuperscript{395}

In Western Australia, the Hospital Benefit Fund (HBF) offers a rebate if a woman is delivered at home by a community midwife who is in private practice and registered with the Nurses' Board of Western Australia. A woman has to be a member of the health fund for at least 10 months before she is eligible for a rebate and the size of the rebate depends upon which hospital table she is paying. For "basic" and "intermediate" tables, the rebate is $350 and for "top cover", the rebate is $400. The rebate only covers the delivery and not postnatal domiciliary midwifery services.

No rebate is available if a complication occurs during the home delivery and the woman has to be taken to hospital to have her baby. There is also no rebate for a woman who wishes to have a hospital delivery with a community midwife.

The Committee heard from a witness that independent midwives are currently negotiating with HBF over this issue.

The Health Insurance Fund of WA introduced a benefit five years ago in response to members who wished to have a homebirth.\textsuperscript{396} The refund has now been extended to births in the Family Birth Centre at King Edward Memorial Hospital for Women. The refund is paid only if the midwife is a registered nurse. To qualify for the benefit, a member must contribute to any hospital table plus the ancillary table for a minimum of 10 months. Contributions may be paid as a single or a family rate. The benefits are $600 for basic hospital, $700 for Supplementary One Hospital and $800 for Supplementary Two Hospital. Should the mother require hospitalisation on the same day as the confinement, only the fees charged by either the hospital or the midwife will qualify for refund.

National Mutual Health provides benefits for a maximum of 10 postnatal home visits by registered midwives in private practice but benefits are not offered for a homebirth and/or antenatal midwifery services.\textsuperscript{397} National Mutual Health's obstetric benefits, including homebirths, hospital benefits, post and antenatal midwifery services are currently under review.

Medibank Private notified the Committee that the organisation pays a benefit for services provided by the KEMH Family Birth Centre.\textsuperscript{398} However, no benefit is paid for women who choose to have their babies at home with an independent midwife, or for postnatal domiciliary visits.

\textsuperscript{395} Submission 14 - Ms Theresa Clifford and Ms Bronwyn Key.

\textsuperscript{396} Miss J Boyle, Assistant to Administrator, Health Insurance Fund of WA. Correspondence to the Committee, 7 July 1995.

\textsuperscript{397} Ms Joy Fisher, Customer Service Manager, National Mutual Health. Correspondence to the Committee, 20 July 1995.

\textsuperscript{398} Mr Mark Brandon, State Manager, Medibank Private. Correspondence to the Committee, 27 July 1995.
Recommendation:

The Federal Government should provide Medicare rebates for women who choose to be cared for by a midwife in private practice.

7.3 ROLE OF THE GENERAL PRACTITIONER

The Committee heard from a number of witnesses about the important role of general practitioners in maternity care, particularly in the areas of continuity of care, cooperation and shared care with other health professionals. The Committee also heard of the concern about the decline in the number of GPs who are practising obstetrics.

Dr Harry Cohen (16.2.95) said that he felt -

it was a great pity general practitioners have dropped out of normal obstetric care and that it was the general practitioner's role to follow the babies through and develop links with the family from the pregnancy onwards ... I would like to see them [GPs] delivering normal births at King Edward. It is a pity that fewer GPs are involved with obstetrics, because it could be easily shared with general practitioners and trained midwives.

According to Klein and Zander (1989), the general practitioner is different from all other providers of health care because "they alone are responsible for providing long-term personal, comprehensive, and continuing health care to individuals and their families".

They concluded that the general practitioner -

has an important role to play in care during pregnancy and childbirth ... not to assume the right or responsibility to give that care in its entirety, but to assist the woman and her partner to obtain the care they need. The family doctor's ongoing relationship with the family makes her or him uniquely capable of fulfilling that role.

They suggest that the role of the GP will vary depending on the circumstances. In isolated areas they state "doctors will best serve by giving virtually total care" while in other situations a commitment to the needs of the childbearing woman and her family "would suggest a close cooperation with community midwives".

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The NHS Management Executive report *A Study of Midwife and GP-led Maternity units* concluded "that GPs add value to two important areas of maternity care ... medical care for the woman" and "continuity of care and support for the woman and her family".

A GP and his patient should have the opportunity to share the birth experience through antenatal care, confinement and postnatal care in all situations perceived to be normal, and in those abnormal situations within the competence of the general practitioner.

### 7.3.1 GP Demographics

The Australian Bureau of Statistics (ABS) Population Census (1991) indicated that there were 3,271 medical practitioners (GPs and specialists) working in Western Australia. In 1993, Hyndman, Hobbs and Kroll conducted a survey of doctors in WA and found that the number of respondents who worked as clinicians (3,005) compared well with the ABS figures. Of those respondents, 1,328 (44%) were GPs.

#### Age

The majority of GPs were 35 years of age and over (80.2%). Over one third (36.5%) are aged 35-44 years of age.

#### Gender

Most general practitioners working in Western Australia are male (70.7%).

#### Registration and graduation

The majority of GPs (76.9%) registered before 1985 and almost two thirds (65.1%) of them graduated in Australia.

#### GP distribution

One thousand and thirty two GPs worked in the metropolitan area and 296 worked in the country. The rate of provision of general practitioners within the metropolitan area was 0.91 per 1000 population. In the non-metropolitan area, the rate was 0.66 per 1000. The Pilbara, Midwest and Goldfields Health Regions had slightly poorer GP per capita ratios than other country health regions.

#### Area of interest

Of the 1,328 general practitioners surveyed, 195 reported that they had a special area of interest. Twenty out of 195 (10.3%) mentioned obstetrics or confinements. Thirteen doctors (6.7%) mentioned anaesthesia or acupuncture.

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401 RACGP, Rural Doctors Association of Western Australia, RACOG and Health Department of Western Australia. *Report to the Minister for Health from the Ministerial Joint Working Party on General Practice Obstetrics*. April 1993; p 7.


The Health Insurance Commission (HIC) informed the Committee that in 1994, there were 118 practising GP obstetricians (GPs who performed five or more deliveries a year) in Western Australia.

7.3.2 Decline in the Number of GP Obstetricians

The Committee heard a significant amount of evidence about the decline in the number of general practitioners who wish to continue providing birthing services in Western Australia. This issue does not appear to be unique to this State.

From 1988-1992, the number of GPs in Australia who performed more than five private patient confinements (including caesarean sections) annually, had declined by 37.2%. However, it should be noted that this does not give a complete picture because "it is likely that GPs continue to provide at least the nonprocedural components of the birthing services quite extensively" and in addition, data is not readily available about "the confinement element of birthing services to public patients [which] may be provided by a GP or specialist in a public hospital".

In Western Australia, the number of practising GP obstetricians in both the metropolitan and country areas has declined between 1992 and 1994 (Table 30).

Table 30: NUMBER OF PRACTISING PROVIDERS (GP OBSTETRICIANS*) IN METROPOLITAN WA AND COUNTRY WA, BY YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Metropolitan WA</th>
<th>Country WA</th>
<th>Total WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>65</td>
<td>91</td>
<td>156</td>
</tr>
<tr>
<td>1993</td>
<td>60</td>
<td>78</td>
<td>138</td>
</tr>
<tr>
<td>1994</td>
<td>46</td>
<td>72</td>
<td>118</td>
</tr>
</tbody>
</table>

* GPs who performed five or more deliveries a year.
SOURCE: Health Insurance Commission


405 ibid.

406 ibid.
Reasons for the decline in numbers

The reasons given for the decline in the number of GPs providing birthing services are complex and varied. Many witnesses expressed opinions which agreed with the study conducted by Welch and Power (1994) from the Western Australian Centre for Remote and Rural Medicine (WACRRM). The reasons they cited include:

- restricted hospital access, community expectations of "specialist care", inadequate remuneration, the disincentives of litigation and medical defence premiums, lifestyle pressures, family commitments and further study, lack of obstetric patients to maintain skills and consequent lack of confidence in acquired skills, obstetrics can be extremely disruptive in a busy general practice.
- The rural doctors added: The lack of proper training facilities for general practitioners at King Edward Memorial Hospital and particularly as regards minimum experiential training that should occur for rural general practitioners to be confident in obstetric, anaesthetic and neonatal paediatric management.

Additional reasons include:

- lifestyle factors such as irregular hours are commonly cited as a reason for discontinuing practice. More recently, the rate of remuneration, medical indemnity costs and fear of lawsuits have been increasingly cited as important contributory factors.

The Committee heard from Dr Roly Bott (9.2.95) that:

- one of the problems for the general practitioner today is finding guaranteed access to specialist support with the number of specialists dropping out of obstetric practice and those not willing to see public patients. If I have a public patient who may be at risk, and should something crop up outside my expertise, I must be sure at the end of the day of getting access to specialist help. The difficulty in doing that is an increasing worry. If I drop out of obstetrics, it will most likely be for that reason.

Dr Katrina Alexander (9.2.95) told the Committee:

- one is not having enough patients because the patients perceive that they need to see a specialist even if they are low-risk ... The GPs are being squeezed out of doing normal confinements
- and
- 71% of women in Australia are low-risk at the beginning of their pregnancy but only 18% of deliveries are done by GPs [25% in WA].

The increase in childbirth technology is also thought to account for the decline in the number of general practitioners involved in pregnancy and childbirth. It has helped to encourage the attitude among GPs and many of their specialist colleagues that the management of childbirth should be left to the experts.

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The Osborne Division of General Practice Inc. in Western Australia cited three factors involved in the decline of general practitioners:\(^{410}\)

In the city, most privately insured patients elect to receive their obstetric care from a specialist obstetrician, leaving GPs to manage uninsured patients who are confined in public hospitals at the public hospital rate of practitioner reimbursement. The low fees do not provide adequate recompense for the stresses.

Rising litigation rates create significant anxiety for all practitioners managing deliveries.

(There is) increased difficulty in finding fellow GPs to provide backup during holiday periods, weekends, etc. thereby disrupting family and social life.

Dr Brian Williams, Director of WACRRM (12.4.95) told the Committee that -

the responsibility, both time-wise and family-commitment-wise to practise obstetrics, is considerable and I have no doubt that there are some practitioners who choose not to do obstetrics for those reasons.

However, Dr Williams added -

of all the issues that are facing the practice of obstetrics in the country areas, it is the indemnity issue that is frightening most of the rural doctors ... There is no question that the rising indemnity cost ... is a factor. Many of the rural doctors are questioning the economic viability of continuing because of the indemnity costs.

Dr Harry Cohen (16.2.95) agreed that the legal issues were very important. "The litigation aspect is such a worry to general practitioners that unless they can deal with the issue, they will not encourage GPs back into that area."

The effect of the threat of litigation and complaint as a deterrent to doctors remaining in or entering the field of obstetrics is discussed in Chapter Ten.

These rates of complaint and litigation may well act to deter doctors from entering obstetrics and gynaecology and may discourage GPs, particularly those in rural and remote areas, from performing obstetric procedures.

### 7.3.3 Incentives for GPs

The Committee heard various suggestions about ways to encourage GPs back to obstetrics.

Dr Keith Woollard (9.2.95) told the Committee -

remuneration is one of the answers. Getting more doctors and better support for general practitioners who want to do obstetrics is probably a more important way of doing that, in the same way as we have dealt with the rural medicine problem in this State - not particularly by giving large sums of money to country doctors, but by providing better support mechanisms ...

My obstetric colleagues tell me they would like to ... help the general practitioners back into it. Having said that, general practitioner remuneration for obstetric care is grossly inadequate.

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\(^{410}\) Submission 35 - Osborne Division of General Practice Inc.
Financial incentives alone may not be sufficient to reverse the decline in numbers. Research cited by the report *Compensation and Professional Indemnity in Health Care* found that -

family physicians did not reverse their decision not to practise obstetrics even when the reported precipitating factor in that decision, that is, the cost of professional indemnity premiums, was corrected.  

Providing opportunities for GPs to practise and to reskill might encourage them back into the system. Dr Katrina Alexander (9.2.95) told the Committee -

we have teaching hospitals training GPs and awarding the diplomas for obstetrics, but then not giving GPs admitting rights to the teaching hospitals. There is no GP involvement in the maternity section of the hospital at all. [There should be] general practice obstetrics units in non-teaching hospitals and re-skilling programs to get GPs back into obstetrics.

Reskilling is discussed further in Chapter Eight.

**Improvements in conditions of employment**

The Committee heard that in order to encourage more GPs to practise obstetrics within the Swan Health Service area, Swan District Hospital is providing indemnity cover for doctors and the doctors are being contracted on a roster system to help cope with the antisocial hours.

Dr Cohen (16.2.95) agreed with the Committee that if GPs were to be encouraged into the public system and the system would in turn pick up the cost of litigation insurance and give doctors assurance that they would be backed by the hospital, this would remove "much of the emotional angst".

The Health Department of Western Australia is currently working on a draft protocol entitled *Protocol for Cooperation in Litigation and Potential Litigation*. However, there are concerns that this has no status in law and that until legislation is put in place in Western Australia to indemnify doctors employed by the State, doctors do not have security. The issue of professional indemnity is discussed more fully in Chapter Ten.

**Recommendation:**

Both metropolitan and country-based GP obstetricians should be encouraged back to obstetrics as part of a shared care team with midwives. Strategies to encourage them back should include, financial incentives, professional indemnity and training, e.g. the type of program offered and organised by the Western Australian Centre for Remote and Rural Medicine as part of the rural training in obstetrics should also be available for selected metropolitan GPs.

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7.3.4 Rural GP Obstetricians

The *Ministerial Joint Working Party on General Practice Obstetrics* suggested that "the role of the rural GP obstetrician differs significantly from that of his city colleague. There is a considerably higher content of procedural and higher risk work."\(^{412}\)

According to WACRRM's figures, in 1994 there were 333 country GPs and currently (12.4.95) only one town in the State does not have a medical practitioner. Following a survey of country GPs, it was discovered that 43% of all respondents held formal obstetric and gynaecological postgraduate qualifications while 59% of GPs currently practising obstetrics held these qualifications. Seventy percent of all respondents had formal obstetric postgraduate qualifications.\(^{413}\)

The HIC data indicated that in 1994, 72 GP obstetricians (defined by the HIC as GPs who performed five or more deliveries a year) were practising obstetrics in country Western Australia compared to 91 in 1992.

Recommendation:

Funding to the Western Australian Centre for Remote and Rural Medicine must be maintained to allow the continuation of its present activities, training and support programs for GPs who practise obstetrics in Western Australia. This must occur for many years to come in order to achieve the optimal result.

Incentive schemes for rural GPs

"One of the greatest health care problems facing rural and remote regions is the shortage of general practitioners."\(^{414}\) The Commonwealth Department of Human Services and Health's *General Practice Rural Incentives Program* has been established to attract and retain GPs in rural and remote areas of Australia. The program has been allocated $15.1 million annually (indexed) from 1993-94. It provides relocation grants; training grants; help with continuing medical education and locum relief; grants for GPs in remote areas; support at the undergraduate level and family support grants.

The Committee heard of other incentive schemes which have been established to encourage GP obstetricians to work in rural areas.

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\(^{412}\) RACGP, Rural Doctors Association of Western Australia, RACOG and Health Department of Western Australia. *Report to the Minister for Health from the Joint Working Party on General Practice Obstetrics.* 1993; p 8.


As mentioned previously, Dr Brian Williams (12.4.95) told the Committee that "many of the rural doctors are questioning the economic viability of continuing [to practise obstetrics] because of the indemnity costs". In 1993-94, the Commissioner of Health in Western Australia "in a one-off gesture committed $50,000 to WACRRM to distribute among rural doctors to offset the indemnity costs for those that are doing small numbers of deliveries".

In February 1995, the New South Wales State Government announced a funding boost to try to retain GP obstetricians in rural areas following negotiations between the NSW Health Department and the Rural Doctors Association of NSW. The total amount proposed is $1.6 million of which $1.42 million is to be used for GP obstetrics and the remaining $180,000 is to be distributed to rural accredited anaesthetists. For the purposes of the grant, a GP obstetrician is defined as -

- a GP with VMO (Visiting Medical Officer) status including obstetric privileges at a NSW rural hospital. They must have been appointed for a period of three months before being eligible for any incentive payments.415

Funds are to be distributed amongst GP obstetricians equally. This ensures that all GP obstetrician receive an adequate incentive regardless of the number of deliveries they do. Those who do greater numbers receive their extra incentive through a fee for service.

This initial $1.6 million boost, accompanied by $2.7 million annual funding from 1995/96, will ensure that obstetric services are increased.

Obstetricians from city areas may be encouraged to move their practice to the country because the financial incentives are greater.416

Recommendation:

The Western Australian Government should provide some financial incentives to Western Australian GPs, who practise obstetrics, who may not receive a Commonwealth grant as part of the Rural Incentive Program, to encourage them to continue to practise in the country.

The Committee also heard from Mr Nigel McBride (26.4.95) about a local health service board in Western Australia that paid for a doctor’s medical insurance because its community wanted a GP who did obstetrics.

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415 Rural Doctors Association NSW Proposals for distribution of obstetric incentive funding 1.7.94. - 30.6.95. Sent to the Committee by Greg Wallin, NSW Health Department.

7.4 ROLE OF THE OBSTETRICIAN

According to Parboosingh, Keirse & Enkin (1989)\textsuperscript{417} -

the specialist obstetrician plays a major role in the totality of care provided for pregnant women and their babies. That role should be limited in terms of the total volume of care, but it is indispensable for the total quality of care.

The Committee heard from various witnesses about the role of obstetricians.

Dr Graham Smith, Chairman of the Western Australian Committee of the Royal Australian College of Obstetricians and Gynaecologists (9.2.95) stated -

the specialist is trained to deal with complicated, difficult situations. Ideally that is what the specialist's work should consist of. I do not think a highly skilled, experienced obstetrician should spend all his time looking after normal, healthy, pregnant women.

He also said -

people who are starting off in obstetrics and gynaecology may be prepared to accept large numbers of apparently normal obstetric cases to get themselves established professionally. The only way to change it would be to introduce a very rigid system of control and referrals - with some kind of financial incentive.

In his submission to the Committee, Dr Ralph Hickling\textsuperscript{418} said -

in some situations such as private hospitals most confinements are conducted by specialists who thus practise both normal and abnormal confinements. In peripheral hospitals GPs conduct more confinements and the specialist is then called for abnormal cases. In some situations GPs deal with any situation which does not require a caesarean section, and the specialist is called in only for those.

The outcome tends to be unsatisfactory where the specialist undertakes overall care as he/she takes less interest than the GP in the patient's general welfare. The specialist who is called for specific tasks such as caesarean sections, anaesthesia, or a specific problem with the baby is more appreciated.

The Committee heard from Dr Katrina Alexander (9.2.95) that -

over the years people have expected to have specialist care ... many women with low-risk who do not need specialist care are seeing specialists for their confinements.

One of the objectives recommended by the Expert Maternity Group in the UK\textsuperscript{419} was that -

the knowledge and skill of the obstetrician should be used primarily to provide advice, support and expertise for those women who have complicated pregnancies.


\textsuperscript{418} Submission 10 - Dr Ralph Hickling.

\textsuperscript{419} Department of Health. Changing Childbirth 1993; p 41.
Trust and good working relationships based on a mutual understanding are paramount. Clarity about roles and responsibilities is also essential and this should be expressed in agreed guidelines, which specify ... the circumstances under which a woman's care may be led by a midwife or GP, and under which circumstances she should be transferred to consultant care.\textsuperscript{420}

The role of the specialist with regard to general practice, and with respect to the general practitioner, is to be the person to whom the GP refers for consultation when the GP becomes aware of a problem beyond the GP's competence or experience. The specialist is part of the essential team required for the safe and optimum management of pregnancy and labour. The specialist obstetrician has the integral role as the primary care giver in the management of high-risk pregnancy.\textsuperscript{421}

The Committee recognised the opportunity for a much expanded role for specialists as consultants. This is addressed in Chapter Seven's recommendations and in Chapter Thirteen.

### 7.4.1 Specialist Demographics

Data provided by the Royal Australian College of Obstetricians and Gynaecologists (RACOG) indicates, that at 16 August 1994, there were 80 Fellows of the RACOG in Western Australia. Sixty-six were male and 14 were female. In addition, there were five Members of the College (Table 31).\textsuperscript{422}

<table>
<thead>
<tr>
<th>Category</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellows</td>
<td>66</td>
<td>14</td>
</tr>
<tr>
<td>Members</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Retired Fellows/Members</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Trainees (pre-Members)</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Diplomates</td>
<td>183</td>
<td>91</td>
</tr>
</tbody>
</table>

* These figures were correct at 16 August 1994.  

SOURCE: RACOG.

In 1993, Hyndman, Hobbs and Kroll conducted a survey of doctors in WA.\textsuperscript{423} Of the respondents, 1,060 were specialists and 274 were specialists-in-training. Respondents were asked to indicate their field of specialist qualification. Ninety stated obstetrics and gynaecology (74 qualified specialists practised obstetrics and gynaecology, 12 were specialists in training and the remainder were not practising in their field of qualification and are not included in the following demographic data.)


\textsuperscript{421} RACGP, Rural Doctors Association of Western Australia, RACOG and Health Department of Western Australia. *Report from the Ministerial Joint Working Party on General Practice Obstetrics.* April 1993; p 8.

\textsuperscript{422} Belton H. College Librarian, RACOG, Victoria.

\textsuperscript{423} Hyndman, *et al.* 1993.
Age

All specialists were 35 years of age and over. The mean age was 50 years. The mean age of the trainees was 32 years.

Gender

The majority of qualified specialists were male (81.1%) while only 50% of trainees were male.

Specialist distribution

In 1993, 67 specialists worked in the metropolitan area and seven worked in a number of Health Regions - South West (2), Goldfields (1), Great Southern (1), Pilbara (1) and Kimberley (2). In 1995, only five Western Australian obstetricians work outside the metropolitan area. They are located in Kalgoorlie, Bunbury (2), Port Hedland and Geraldton. Until recently there was a specialist in Albany. The town is now serviced by a specialist from the metropolitan area who visits once a month.

Sector of work

Specialist obstetricians and gynaecologists are more oriented towards private practice, with 83.8% of them working in the private sector.

Hours worked

Specialists in the metropolitan area worked an average of 59 hours per week while those in the country recorded 70 hours per week.

7.4.2 Decline in the Number of Specialist Obstetricians

Figures from the HIC indicate that between 1992 and 1994, there has been a decline in the number of specialist obstetricians in the Perth metropolitan area from 55 to 47 (Table 32). The number of specialist obstetricians in the country has remained low over the same period of time.

Table 32: NUMBER OF PRACTISING PROVIDERS* (SPECIALIST OBSTETRICIANS) IN METROPOLITAN WA AND COUNTRY WA, BY YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Metropolitan WA</th>
<th>Country WA</th>
<th>Total WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>55</td>
<td>4</td>
<td>59</td>
</tr>
<tr>
<td>1993</td>
<td>49</td>
<td>6</td>
<td>55</td>
</tr>
<tr>
<td>1994</td>
<td>47</td>
<td>7</td>
<td>54</td>
</tr>
</tbody>
</table>

* Specialists who performed five or more deliveries a year
SOURCE: Health Insurance Commission

The Committee heard from several witnesses that obstetricians are leaving the field and moving into gynaecology. Dr Graham Smith (9.2.95) told the Committee that he had just conducted a telephone survey of all the gynaecologists in the State in which he spoke to 84 of them. "Only 43 are doing obstetrics" and they are accepting new obstetric patients. He also
asked them how many confinements do they anticipate for the next 12 months? "The great majority said between 100 to 200. Some were doing as few as 10 and two told me they were doing 600".

Reasons for the decline in the number of specialist obstetricians

The Committee heard from Dr Smith (9.2.95) that -

traditionally, the younger doctors did the obstetrics and as they got more established they moved into surgery and the more advanced hospital work and eased out of obstetrics. Unfortunately, people are now coming through training and going into subspecialities and dodging obstetrics.

The reasons for the decline in the number of specialists who wish to practise obstetrics are similar to those mentioned for GPs. The fear of litigation and issues of professional indemnity are addressed in Chapter Ten.

Country specialists

According to Mr Val Lishman of Bunbury (representing the Provincial Surgeons Association of Western Australia), the main reasons for the decline in numbers are "lifestyle, which means nights and weekends are taken up with obstetric work, another is the remuneration and the third is the possibility of litigation".424

The Committee heard that because of the decline in the number of obstetricians in country areas -

the single most important operation that a general surgeon must be able to perform in the country is an emergency caesarean section ... However, because of the increasingly difficult medico-legal climate, almost all general surgeons are becoming increasingly reluctant to undertake emergency surgery outside their own specific area of training and expertise.425

Mr Lishman would like to see special consideration being given to general surgeons opting to work in the country, particularly in remote areas "so that they can be given adequate experience in emergency operative obstetrics". He found that only nine out of 420 non-metropolitan general surgeons in Australia had a postgraduate Diploma in Obstetrics.

Recommendation:

Incentive programs for rural specialist obstetricians need to be developed.

424 High cost of litigation reduces number of country obstetricians. Article in The Elders Weekly; June 1995.

425 Submission 13 - Mr I V Lishman.
Recommendation:

General surgeons who work in country areas must be given the opportunity to maintain or improve their skills in obstetric operative procedures by having a special short-term posting at a tertiary training institution.

7.4.3 Specialist Remuneration

The Committee heard from some specialists about remuneration.

Dr Graham Smith (9.2.95) told the Committee -

there is a requirement that I see a patient four or five times late in the pregnancy, otherwise I will not be able to bill her. The GP and specialist share the antenatal visit fees but the GP does not get paid for the confinement if the specialist is supervising it.

Dr Smith also told the Committee "our services are undervalued and underfinanced. We do not feel we are getting adequate remuneration."

Some witnesses felt that there was no remuneration to motivate medical practitioners to not intervene in childbirth.\textsuperscript{426}

If a specialist is called in by a GP to give advice only, they can receive a specialist referral fee (Item 104) but if the specialist is called in and takes over the confinement they are paid for a "confinement as an independent procedure by a specialist".\textsuperscript{427}

There is further discussion and recommendations about remuneration in Chapter Thirteen, Section 13.4.2.

Recommendation:

Obstetricians should be encouraged to act in a consultative role in support of a shared care approach by GPs and midwives. Incentives such as better remuneration for consultancy should be considered.

\textsuperscript{426} Submission 37 - Ms Kathleen Smedley and Ms Joanne Davies.

**RECOMMENDATIONS**

**Recommendation:**
Midwives should be encouraged to work in close cooperation with GPs and specialist obstetricians as part of a "shared care" team. The midwife should be the lead professional for those low-risk deliveries.

**Recommendation:**
The Committee endorses the new direction by the Director of Nursing at King Edward Memorial Hospital for Women to allow staff to rotate through antenatal, labour and delivery, and postnatal areas.

**Recommendation:**
There should be encouragement and opportunity for more midwives to train in order to obtain their accreditation with the Australian College of Midwives Inc, which will in turn allow them to apply for hospital accreditation.

**Recommendation:**
Midwives in private practice who have accreditation at the Family Birth Centre should now be accredited to the hospital delivery suite at King Edward Memorial Hospital for Women in order to improve continuity of care with the Family Birth Centre.

**Recommendation:**
The Federal Government should provide Medicare rebates for women who choose to be cared for by a midwife in private practice.
Recommendation:

Both metropolitan and country-based GP obstetricians should be encouraged back to obstetrics as part of a shared care team with midwives. Strategies to encourage them back should include, financial incentives, professional indemnity and training, e.g. the type of program offered and organised by the Western Australian Centre for Remote and Rural Medicine as part of the rural training in obstetrics should also be available for selected metropolitan GPs.

Recommendation:

Funding to the Western Australian Centre for Remote and Rural Medicine must be maintained to allow the continuation of its present activities, training and support programs for GPs who practise obstetrics in Western Australia. This must occur for many years to come in order to achieve the optimal result.

Recommendation:

The Western Australian Government should provide some financial incentives to Western Australian GPs, who practise obstetrics, who may not receive a Commonwealth grant as part of the Rural Incentive Program, to encourage them to continue to practise in the country.

Recommendation:

Incentive programs for rural specialist obstetricians need to be developed.

Recommendation:

General surgeons who work in country areas must be given the opportunity to maintain or improve their skills in obstetric operative procedures by having a special short-term posting at a tertiary training institution.
Recommendation:

Obstetricians should be encouraged to act in a consultative role in support of a shared care approach by GPs and midwives. Incentives such as better remuneration for consultancy should be considered.
CHAPTER EIGHT

PROFESSIONAL EDUCATION AND TRAINING

8.1 INTRODUCTION

The Committee heard from a number of witnesses, confirming submissions, that many professionals experience mainly high-risk births during their training and are not exposed to enough normal deliveries.

The current curricular training provides insufficient observation and care of women having natural childbirth. Hence educating practitioners with a focus on intervention and control rather than observation, support and encouragement.  

Dr Mark McKenna believes that "the expectations of medical and nurse practitioners working in a particular area is coloured by their experience". It is important to ensure that staff get adequate exposure to both high and low-risk obstetrics. Therefore, he recommends that "there should be some form of rotation between high-risk and low-risk units where these are run by the same employer".

Training could "promote doctors and midwives working together for a successful outcome". The report on Compensation and Professional Indemnity in Health Care recommended that

improving communication between health care professionals and their patients be pursued in all relevant contexts, including health care practitioner training at undergraduate and postgraduate levels and in continuing medical education through the Family Medicine Program, Best Practice in the Health Sector Program and the Rural Health Support, Education and Training Program.

8.2 TRAINING OF MIDWIVES

The Australian College of Midwives Inc.'s (ACMI) Standards for the Practice of Midwifery has included a section on education in midwifery in its philosophy.

In order to function effectively as a member of a multidisciplinary team in the complexity of a rapidly changing system, the midwife has a need for knowledge from a variety of disciplines as well as knowledge of self and society.

With the trend towards specialisation, changing technologies, and the assumption of new roles, midwives believe that accountability for providing and maintaining the quality and continuity of care is the responsibility of the individual midwife. Midwives recognise the importance of

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428 Submission 14 - Ms Theresa Clifford and Ms Bronwyn Key.

429 Submission 3 - Dr Mark McKenna.

430 Submission 38 - Ms Dianne Tomlinson.

continuing education designed to meet individual interests and needs and based on the principles of adult education.

Encouragement is given to the development of ongoing education at regional and central centres.

There is a recognised need to support research activities directed toward broadening and clarifying the scientific base of midwifery practice in order to meet the challenge of providing quality midwifery care. 432

There was a great deal of debate surrounding midwifery education and the advantages and disadvantages of university versus hospital training.

At the present time, Western Australian midwifery education programs are conducted in both in a hospital and in tertiary institutions. The Committee heard from Ms Joan Greenwood (8.8.94) that -

it seems to me there is a great deal of scope to look at midwifery education in Western Australia ... it is a very short course in comparison with what we have had to extend it to in the United Kingdom ... There is a problem with getting sufficient clinical expertise, which is what student midwives need ... there is a very solid program of midwifery training based at King Edward [and] the students come out ready to practise as midwives, whereas the university program is shorter and is heavily theoretically based.

Ms Carol Thorogood, President of the West Australian Branch of the Australian College of Midwives Inc. (27.4.95) told the Committee -

the Australian College of Midwives has always been of the opinion that midwifery education should take place in tertiary institutions;

and
tertiary educated nurses are better able to deal with the complexities of society today. One of the great advantages of the Curtin University program is that the students are able to go to a variety of hospitals and work in the community. They spend time in rural areas and are not confined to taking the clinical practice in the only tertiary hospital we have.

The Victorian Ministerial Review of Birthing Services *Having a Baby in Victoria* found that "overall, there appeared to be support for midwife education to move into the tertiary sector". 433

8.2.1 International Differences in Training

In the United Kingdom, the program of midwifery education is not less than three years in length for students with no previous nursing experience or not less than 18 months in length for students who have been registered as first level nurses trained in general nursing or first level nurses trained in adult nursing. 434

Ms Janice Butt, Coordinator of the Midwifery Course at King Edward Memorial Hospital for Women (16.2.95) explained to the Committee that one of the differences between the United Kingdom and Australia is that -
in Australia there is no central governing body for midwifery education. Therefore, different States can do different things and the courses can be entirely different. In the United Kingdom and the rest of Europe, central bodies govern education and all courses must meet exactly the same outcomes.

There are European Economic Community directives which specify the amount of practical experience students require in their course. Ms Butt told the Committee that Australian midwives do not get enough practical experience.

The hospital course is 52 weeks and the university-based courses provide considerably less practical experience. They are even less likely to be accepted in Europe.

and

Australian trained midwives can register with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting as a nurse but cannot register as a midwife.

8.2.2 Midwifery Syllabus

The Nurses' Board of Western Australia has a role in relation to education. The Objects of the Nurses' Act 1992 defines the Board's role -

! to promote suitable standards of knowledge and clinical skills among nurses for the purpose of protecting the health of the people of Western Australia;

! to establish and maintain suitable standards of education among nurses.

The Nurses' Board also submitted information about the midwifery syllabus to the Committee. 435 The objectives of the syllabus are as follows -

At the completion of this course the nurse will be able to -

1. appreciate the importance of and actively promote the health and wellbeing of families, appropriate to the cultural, social and economic circumstances;

2. apply the nursing process to meet the health needs of women during pregnancy, childbirth and the puerperium;

3. apply knowledge from biological sciences to identify risk factors and deviations from normal in obstetrics and implement appropriate nursing action;

4. demonstrate a knowledge of the legal and professional aspects of midwifery.

Individual schools of nursing are free to plan their curriculum in the sequence of theory and practice most appropriate for their setting, relating concepts from all areas in the care of the family unit. As midwifery students are professional nurses they can be expected and encouraged to be self-directive and positive in using the opportunities provided for their development in the art and science of midwifery.

In addition, the Nurses' Board has prepared a document Competencies of Graduate of Midwifery Education Programme 436 which outlines the competencies of the registered nurse and essential midwifery intervention skills (Appendix F).

435 Submission 19 - Nurses' Board of Western Australia.

436 Nurses' Board of Western Australia. Competencies of graduate of midwifery education program.
The Committee heard that midwifery training needs to include more practical experience.\(^{437}\)

I would like to see the focus shifted to the "normal" with information regarding the "abnormal" available. I would like to see flexible attitudes imparted to student midwives ... with a focus on "active labour" ... and given knowledge of group dynamics that allows women in a prenatal situation to make choices.\(^{438}\)

### 8.2.3 Hospital Training

In the past, midwives trained at King Edward Memorial Hospital for Women (KEMH). Over the past few years, there has been a gradual decline in the numbers of students participating in the certified program at KEMH. In 1991-92, 79 students completed registration examinations, while in 1993-94, 43 passed the exams.\(^{439}\) The anticipated completion date for the transfer of midwifery education to the tertiary sector is February 1997. KEMH still takes applicants without a nursing degree. The School of Nursing based at KEMH, must meet the criteria outlined in the Nurses' Board of WA policy document *Criteria for conduct of a midwifery course at King Edward Memorial Hospital for Women, School of Nursing.*\(^{440}\)

### 8.2.4 University Training

A tertiary midwifery course is being conducted at Curtin University of Technology and is subject to guidelines outlined in the Nurses' Board of WA document *Guidelines for approval of an education qualification from a Western Australian tertiary education institution.*\(^{441}\) Students at Edith Cowan University cannot obtain a formal midwifery qualification but they can undertake study and research in related areas (see Chapter Nine).

**Enrolment requirements**

Students wishing to enter the midwifery course at Curtin University must meet the requirements of the Nurses' Board and Curtin University. The entrance requirements to the midwifery course include one year post-registration experience plus a degree in nursing or a related discipline. School leavers will spend three years at Edith Cowan University or three and a half years at Curtin University of Technology to gain their general nursing degree while nurses who were hospital-trained and do not have a degree are required to complete a shorter course in order to gain their general nursing degree.

At Edith Cowan University, the Bachelor of Nursing course (for Registered Nurses - Hospital Trained) is designed to upgrade to a Bachelor of Nursing the qualifications of existing registered nurses with a hospital-based diploma award. The course requires 12 months of full-time study or the part-time equivalent. In addition, the Bachelor of Nursing course

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\(^{437}\) Submission 36 - Mr Bruce Coulson.

\(^{438}\) Submission 38 - Ms Dianne Tomlinson.

\(^{439}\) Data tabled before the Committee by Mrs Barbara Horner, Nurses' Board of Western Australia (16.2.95).

\(^{440}\) Nurses' Board of Western Australia. *Criteria for conduct of a midwifery course at King Edward Memorial Hospital for Women, School of Nursing.* Information tabled before the Committee by Mrs Barbara Horner (16.2.95).

\(^{441}\) Nurses' Board of WA. *Guidelines for the approval of an education qualification from a Western Australian tertiary institution.*
(conversion of a tertiary based diploma) is designed to upgrade the qualifications of existing registered nurses with a tertiary level diploma award. The course requires six months full-time study or the part-time equivalent.

At Curtin University, a hospital trained registered nurse can upgrade their qualification to a degree in 18 months of full-time study. Graduates from the Diploma of Applied Science (Nursing) may convert to a Bachelor of Science (Nursing) by completing a further six months full-time study or equivalent at the University.

The Bachelor of Science (Nursing) can be studied, in part, at regional centres throughout the State, at Kalgoorlie, Karratha, Geraldton, South Hedland and Albany.

Midwifery courses

Curtin University runs a one year Postgraduate Diploma in Clinical Nursing (Midwifery). The course commenced in 1985.

The design of the course enables students to obtain the Postgraduate Diploma in Clinical Nursing (Midwifery) after completion of the first year, with the option to apply for the Master of Science (Nursing) by coursework degree. Graduates wishing to enrol in the Master of Science (Nursing) by thesis, will need to complete an additional research unit.

Curtin University has proposed a change to the midwifery course. An increase in the amount of clinical experience that students obtain would enable them to practise midwifery in a variety of settings at an advanced level.

As of 27.4.95, there were 63 students registered in the program with a limit of 30 students graduating each year. One of the differences between the hospital and university programs is that the university program can take part-time students and it can accommodate more rural students. The Committee heard from Ms Carol Thorogood (27.4.95) that:

> we have quite a high part-time intake. These students will take the course over two years. Many students have quite heavy financial commitments and find that one year full-time is too much for them at this stage in their careers so they prefer to do the course part-time. Because we have two systems - King Edward's and ours - we could not place more than 30 students satisfactorily in the community and in a variety of hospitals at any one time.

There are clinical placements for students at metropolitan hospitals including KEMH, Wanneroo Hospital, Armadale/Kelmscott Hospital, Bentley Hospital, Swan District Hospital, Osborne Park Hospital, Rockingham/Kwinana Hospital, St Anne's Mercy Hospital and country regional hospitals in Bunbury, Derby and Kalgoorlie. Students are precepted during their hospital placements by experienced midwives. One of the problems is that it is difficult to find clinical experience for students that focuses on low-risk delivery because of the increased rate of intervention in hospitals such as KEMH.

There are few community based areas where students can be precepted by experienced midwife practitioners.

The Committee heard that:

> Glen garry Hospital is not involved in curriculum development of tertiary institutions responsible for the training of doctors, midwives or nurses. The main area of concern is that patients coming
to the hospital tend to regard students unfavourably, mainly as they are paying for private care and expect that care to be delivered by qualified staff.  

**Recommendation:**

**More midwifery training and education should occur at peripheral hospitals in an attempt to give midwives experience of more low-risk deliveries.**

### 8.2.5 Midwifery Centre of Excellence

Staff from Curtin School of Nursing proposed the establishment of a midwifery centre of excellence for clinical practice and research so that "students could see in practice the role model of the midwife caring for the normal mother and child in a setting where they could quickly have assistance if needed". The proposal involves collaboration between Curtin University of Technology and a Level 1 clinical facility such as Swan District Hospital birthing centre.

Some witnesses expressed concern that with the end of the hospital-based training course at KEMH, practical and educational experience have been separated. Professor Robin Watts, Head of the School of Nursing at Curtin University (16.2.95) did not agree and told the Committee "I do not believe it has been - staff who teach in the program also supervise students in the clinical area".

### 8.2.6 Direct Entry Training

The Committee heard different opinions about "direct entry" training which allows students to enter a midwifery course without any previous nursing qualifications.

Several European countries have direct entry midwifery courses. The argument put forward to support them is that midwifery and nursing are entirely different. Mrs Henny Ligtermoet (27.4.95) told the Committee that "midwifery deals with health and nursing deals with sickness." Ms Caroline Flint (29.3.95) told the Committee "of course there are medical things I need to know about ... but I can learn that as a midwife without doing all the nursing bit".

Direct entry ensures that a midwife's focus is on birth as a normal life event, rather than a disease and malfunction.

The Nurses' Board of Western Australia opposed the idea of direct entry midwifery while the Australian College of Midwives supports it. However, Ms Carol Thorogood (27.4.95) told the Committee that direct entry poses problems for Western Australian midwives.
"because of our unique geographical situation and because so many midwives work in peripheral and rural hospitals".

In country hospitals, midwives may be required to help in other areas of the hospital if there are staff shortages. In situations like that it would be essential for a midwife to possess a general nursing qualification. Ms Thorogood (27.4.95) said "it is not reasonable for midwives who are not able to work across hospitals and areas to be employed in rural hospitals".

Professor Robin Watts (16.2.95) told the Committee that -

> Western Australia does not have the population base to support a person who can work only in the midwifery area. Particularly in this era of multiskilling, it does not fit with the concept.

She added "I really needed that general training ... the knowledge, skill and intuition built up from general experience is absolutely vital".

Dr Peter Richardson (26.4.95) discussed the possibility of instead of doing a three year nursing course followed by one year of midwifery, a woman with no previous nursing experience could undertake a four year training course for midwives. He told the Committee that -

> I have no problems with having one of our midwifery schools - if the Federal Government would fund it - as a direct entry midwifery school to see at the end of the day whether those midwives who had been trained for four years had raised or lowered the standard.

The Committee received information about the HOME (Homebirth Ongoing Midwifery Education) Birth Manual which is produced by the Home Midwifery Association (Queensland) Inc. The HOME program is a community-based program, based on the philosophy of mothers and midwives working together. It is designed to be adaptable to the needs of both registered midwives wishing to enter homebirth practice and direct entry midwives.

The Committee noted the discussion on direct entry midwifery with interest and will await the outcomes of programs conducted in other parts of Australia.

Across Australia there is a wide range of starting qualifications for practice as a midwife. Mrs Sue Terry⁴⁴⁶ suggested that -

> it would seem appropriate that some consensus is developed about what kind of program will best meet the needs of the profession, health system and the women we serve.

### 8.2.7 Registration

Midwifery students must have current registration as a general nurse when they apply for the course. Once they have successfully completed the hospital course or the Postgraduate Diploma Course they may apply to the Nurses' Board of Western Australia for registration in the specialty area.

### 8.2.8 Continuing Education

⁴⁴⁶ Submission 41 - Mrs Sue Terry.
Continuing education is an important way for midwives to update and expand their expertise and skills. Programs are run by the Australian College of Midwives Inc (ACMI).

Education needs for midwives in country hospitals was discussed. There should be a "focus to make persons like me, true midwives not just obstetric nurses". Education services about all aspects of midwifery could be purchased from current practitioners. There should be liaison "with a regional coordinator who feeds in what midwifery specific educational input is required in [a] region".

**Recommendation:**

Midwives should be encouraged and allowed time to attend continuing education programs.

### 8.3 TRAINING OF MEDICAL UNDERGRADUATES

The Committee had discussions about medical undergraduate training with Dr Mark McKenna, of the University Department of Obstetrics at King Edward Memorial Hospital for Women (26.4.95).

I specifically explain to the students that the standard I require of them in terms of performing a delivery is simply that they be better than a taxi driver, should the situation ever arise before they have the opportunity to do further training.

#### 8.3.1 Current Curriculum

The aims of the current obstetrics and gynaecology curriculum relate to the three major areas of knowledge, skills and attitude.

Medical students in Western Australia learn about pregnancy and childbirth in an eight week block at KEMH in the fifth year and a four week block in the sixth year of their undergraduate training. In the sixth year, students are rotated through Osborne Park Hospital and Wanneroo Hospital. In practice this gives them a good exposure to low-risk antenatal patients. However, it has not proven possible to achieve any significant exposure to the labour wards in these hospitals.

Recommendations from submissions with regard to the undergraduate curriculum include -

1. that the curriculum continue to aim to have students learn about their attitudes as well as basic knowledge and skills;
2. that the curriculum be continually reviewed as is currently the case;

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447 Submission 66 - Mr Patrick O'Donaghue.
448 Submission 3 - Dr Mark McKenna.
449 Submission 3 - Dr Mark McKenna.
that attitudinal and other issues hidden within the curriculum be identified and explored by the students;

that where possible, undergraduate teaching should focus on normal low-risk obstetrics. This of course includes the concept of the recognition of abnormality, and a general idea of what treatment is required when abnormality exists.

There must be more opportunity for students to learn obstetrics outside the tertiary hospital. Peripheral hospitals have a community responsibility to allow training to occur and their budgets should be supplemented to include an allocation directed towards training. The Committee believes that the comfort and wishes of the mother should be at the forefront of decisions about having students present during childbirth.

**Recommendation:**

Peripheral hospitals must allow medical students access to labour wards as part of their training so that they can experience low-risk deliveries first hand.

**Recommendation:**

Medical students should be encouraged by both obstetric and Family Birth Centre staff to experience "natural childbirth" at the Family Birth Centre. The wishes of the mother should be at the forefront of any decision to have a medical student present during labour and delivery.

8.3.2 Country Training

Students are allowed to do their obstetrics and gynaecology training in the country. The Committee endorses the policy of the Department of Obstetrics and Gynaecology to encourage medical students to train in the country.

8.3.3 Midwifery Tutor Position.

The position of Midwifery Tutor is to be established within the University of Western Australia's Department of Obstetrics and Gynaecology. The position will have teaching, clinical and research roles. The rationale behind the appointment is "to introduce medical students to the practice of normal midwifery and to demonstrate the importance of professional team work in maternity care". The position will be for a Level II midwife and it will probably commence in October. The Committee endorses this excellent strategy.
8.4 TRAINING OF GENERAL PRACTITIONERS

Dr Peter Richardson (26.4.95) stated that -

as far as general practitioners and obstetricians in this country are concerned, the quality and
standard organisation for doctors is the RACOG [Royal Australian College of Obstetricians and
Gynaecologists], and the training programs for general practitioners, with the diploma of the
RACOG and membership and fellowship of the Australian college for specialists, have been well
defined.

The Joint Consultative Committee of the Royal Australian College of Obstetricians and
Gynaecologists and the Royal Australian College of General Practitioners approved a three
level training system for general practitioner obstetricians. The three levels were\(^{451}\) -

**Level A** - Training to provide antenatal and postnatal care and to have knowledge about
women's health issues and office gynaecology. Expertise in the care of the healthy infant
would be a component of this level of training. Level A skills could be utilised in metropolitan
areas or in major provincial areas where specialist services exist.

**Level B** - Roughly equivalent to the current Diploma of the Royal Australian College of
Obstetricians and Gynaecologists requirements. Ability to provide obstetric care for healthy
women and their babies in a metropolitan area or country region, providing that the latter is
within one hour of specialist services or has agreed and documented links with a Level C GP
in more remote areas. The GP would provide services for low-risk deliveries.

**Level C** - Training reserved for GPs who would be able to provide additional skills to rural
areas remote from metropolitan areas or major provincial centres. GPs with skills at this level
would be able to care for women with selected problems which have been traditionally classed
in a medium-risk group, e.g. elective caesarean section or vaginal delivery after caesarean
(VBAC).

As of 1 January 1995, the Joint Consultative Committee has been offering two programs for
general practitioners who require further training in women's reproductive health. One
program leads to a Certificate of Satisfactory Completion of Training in Women's Reproductive
Health (CSCT) and the other leads to the Diploma of the RACOG.

8.4.1 Certificate of Satisfactory Completion of Training in Women's Reproductive
Health (CSCT).

Training for the CSCT is for a minimum of three months. The program aims to provide
training for general practitioners who wish to provide -

- shared care and postnatal care with specialist obstetricians, GP obstetricians or
  a specialist hospital;
- office gynaecology;
- family planning.

This training is equivalent to what was previously referred to as Level A.

8.4.2 Diploma of the Royal Australian College of Obstetricians and Gynaecologists (DRACOG)

Training for the DRACOG is for a minimum of six months. The course aims to provide training for GP obstetricians who wish to provide:

- all of the above CSCT aims;
- management of the antenatal care of low to moderate-risk patients;
- performance of normal deliveries, assisted deliveries and, to a limited extent, breech deliveries;
- performance of basic gynaecological procedures.

This training is equivalent to what was previously referred to as Level B.

8.4.3 Re-skilling

A number of witnesses have expressed concern about the lack of experience GPs are getting at delivering babies and the importance of being able to maintain one's skills. A survey conducted by the Joint Consultative Committee of the RACGP and RACOG found that a lack of patients sufficient to maintain the GPs skills and lack of confidence in their own competence were two major factors turning GPs away from obstetrics.

Urban GP obstetrician re-skilling program

Dr Colin Hughes from the Swan Hills Division of General Practice, provided the Committee with a copy of an application for an urban GP obstetrician re-skilling program which provides six half-day sessions at Osborne Park Hospital and King Edward Memorial Hospital for Women for GP obstetricians who need to re-skill in order to be able to run antenatal clinics and provide GP on-call services for the GP/Midwife Obstetric Unit at Swan District Hospital.

Continuing medical education weekend

King Edward Memorial Hospital for Women conducts a continuing medical education weekend for updating obstetrics.

Training in peripheral hospitals

Dr Dale Evans (9.2.95) suggested that -

perhaps you can run rosters of GPs who are interested in obstetrics for one day a week or a fortnight where they get a depth of obstetric experience running a labour ward in some of the peripheral hospitals. That would give them some training.
Recommendation:

Both metropolitan and country-based GP obstetricians should be encouraged back to obstetrics as part of a shared care team with midwives. Strategies to encourage them back should include training, e.g. the type of program offered and organised by the Western Australian Centre for Remote and Rural Medicine as part of the rural training in obstetrics should also be available for selected metropolitan GPs.

8.4.4 Training Curriculum in Obstetrics for Rural General Practice

The curriculum has been developed through the Rural Medicine Curriculum Design Project of the Faculty of Rural Medicine (FRM), Royal Australian College of General Practitioners and was established in response to the identified training needs of current and future rural GPs.

The course has three levels:

- **Level A:** Women’s Health Course (CSCT equivalent)
- **Level B:** Basic Training (DRACOG equivalent)
- **Level C:** Advanced Training.

Level B involves six months training with attachment to an accredited obstetric post associated with a Rural Training Unit (RTU).

Level C involves a further six months of training with either attachment to an accredited obstetric post associated with an RTU for six months or attachment to an accredited obstetric post associated with an RTU for three months and attachment to an accredited rural practice with a significant obstetric workload for a further three months.

8.4.5 Training Costs

Doctors are paid during their training by the hospitals that conduct the above training courses.

Dr Mark McKenna (26.4.95) told the Committee -

> in general practice and specialist training the costs are essentially the time they give up ... when general practitioners come back to train in obstetrics ... if they keep their practice going it will cost a lot to employ a locum.

8.5 TRAINING OF OBSTETRICIANS

Fellowship of the Royal Australian College of Obstetricians and Gynaecologists (FRACOG) is the only Australian postgraduate qualification which leads to the recognition of specialist obstetrician/gynaecologists in Australia. The training program is a structured postgraduate program.
program which leads first to certification as a Member (MRACOG) and then as a Fellow (FRACOG).

The MRACOG takes the equivalent of at least three years of full-time approved training in obstetrics and gynaecology and the FRACOG takes a further three years (six in total).

As at 16 August 1994, there were 80 FRACOG, five MRACOG, 18 Retired Fellows and Members, and 11 trainees in Western Australia.454

Dr Harry Cohen (16.2.95) told the Committee that -

we need to be more critical of our teaching of junior staff ... Senior members of staff [consultants] [should] be on call, not just in close proximity but be there ... teaching the juniors ... The cycle will not be broken until the older senior people are involved. It is not that we are prepared to take more risks, it is just that we have a whole range of experience they do not have.

8.6 TRAINING OF ANAESTHETISTS

There are currently 157 Fellows of the Australian and New Zealand College of Anaesthetists in Western Australia.455 There are other specialist anaesthetists working in WA who trained overseas.

"The College of Anaesthetists places great emphasis on the quality of training in obstetric anaesthesia."456 Within the five year postgraduate training required of a specialist anaesthetist in the Western Australian Training Program, trainees spend a minimum of six months training at King Edward Memorial Hospital for Women where they receive specialised teaching and supervised training in obstetric pharmacology, physiology and techniques for regional and general anaesthesia. The training includes tutorials and experience in other areas of anaesthesia and intensive care. Successful ongoing appraisal, two examinations and completion of a formal project are required before the Diploma of Fellowship is awarded.457 In addition, Perth teaching hospitals have commenced, in cooperation with the RACGP via WACRRM and the Family Medicine Program, a shorter course of supervised training for GP anaesthetists who are planning to or who are already providing obstetric anaesthetic or epidural analgesia services to labouring women.458

In 1991, the Faculty of Anaesthetists acknowledged the position of the GP in a community where no specialist anaesthetic services are available and it released a policy document entitled Essential training for general practitioners proposing to administer anaesthetics.459 The
document outlines the minimum level of training required and stresses that it is essential to maintain and update knowledge and skills.

The need for additional training for rural general practice is well documented and "anaesthesia has been identified as one of the key areas for additional training". In response to the need, a curriculum has been developed through the Rural Medicine Curriculum Design Project of the Faculty of Rural Medicine, RACGP for the education of general practitioners who are proposing to administer anaesthesia in rural general practice.

Dr Michael Paech (8.2.95) told the Committee that medical undergraduates have one month's anaesthetics training as part of the course, and "that is adequate at that time".

Recommendation:

Training programs for anaesthetists should keep up-to-date with information about the most effective methods of analgesia in labour, including non-pharmacological methods.

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Price D. Education for general practitioners proposing to administer anaesthesia in rural general practice. A curriculum statement for a major in anaesthesia in the Rural Training Program of the Faculty of Rural Medicine, Royal Australian College of General Practitioners. Faculty of Rural Medicine 1992.
**RECOMMENDATIONS**

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Recommendation:

Training programs for anaesthetists should keep up-to-date with information about the most effective methods of analgesia in labour, including non-pharmacological methods.
CHAPTER NINE

RELATED RESEARCH IN WESTERN AUSTRALIA

9.1 INTRODUCTION

The Committee heard from a number of witnesses who discussed the importance of research in the area of pregnancy and childbirth. The witnesses felt that several interventions were used in obstetrics which had not been adequately trialled and tested and they recommended that research should be conducted to examine their validity more closely.

While clinical impressions are no longer regarded as acceptable evidence for the introduction of new techniques, there is still a very long way to go to put effective practice into operation.\textsuperscript{461}

Research should be carried out "to obtain accurate and specific data on which to base and then assess the impact of modifications to practice".\textsuperscript{462}

Dr Peter Richardson (26.4.95) told the Committee -

it is important to suggest that proper outcome related trials be conducted, so that methods of treatment and protocols can be firmly established and women who decide on a natural event in the comfort and privacy of their own homes will know they will not be in jeopardy.

Following discussions about electronic fetal heart rate monitoring (EFM), Dr Jan Dickinson (26.4.95) told the Committee "when it came into clinical practice, it [EFM] was not subjected to any randomised control studies".

The Committee is aware of several pieces of research, which have been conducted in Western Australia, which have demonstrated the value of research to maternity care. In 1993, data from the Western Australian Pregnancy Cohort (Raine) Study was published which indicated that it was "plausible that frequent exposure to ultrasound may have influenced fetal growth".\textsuperscript{463}

In addition, research has shown that the majority of cases of cerebral palsy do not occur as a result of intrapartum hypoxia\textsuperscript{464} and that there are many antenatal factors that may lead to cerebral palsy.\textsuperscript{465,466}

9.2 CURRENT RESEARCH IN WESTERN AUSTRALIA

\textsuperscript{461} Submission 25 - Dr Jane Fisher.
\textsuperscript{462} Submission 5 - Dr Michael Paech.
\textsuperscript{465} Blair E and Stanley F. 1993; pp 302-317.
The Committee heard from a number of witnesses about relevant current and proposed research in Western Australia.

9.2.1 King Edward Memorial Hospital for Women (KEMH)

The Committee heard about many research projects being conducted at KEMH which relate to areas covered by this report. Some of the projects are mentioned below.

Staff at KEMH including Clinical Professor John Newnham, Dr Jan Dickinson, Dr Sharon Evans and Dr Michael Paech have applied to the National Health and Medical Research Council (NHMRC) for funding to investigate the effects of epidurals. They intend to conduct a randomised controlled trial to find out if having an epidural increases a woman's chance of having a caesarean section.

The Committee heard from Ms Jenny Wood, a midwife researcher (9.2.95) who is conducting a comparative study of women who attended the Family Birth Centre and women who attended the traditional labour ward.

The Committee heard evidence from Ms Sherryl Pope (8.2.95) who is conducting research into postnatal depression.

Other research projects being conducted at KEMH include -

- determining what pre and perinatal factors influence an infant's temperament;
- the development of a system to predict which women will have low-risk pregnancies suitable for confinement at a low intervention unit such as the Family Birth Centre.

9.2.2 Foundation for Women's and Infants' Health

Many of the research projects conducted at KEMH are funded by the Foundation for Women's and Infants' Health.

The mission of the Foundation is to improve the health of women and infants in Western Australia by promoting and sponsoring high quality research; informing the scientific and broader community of the results and implications of such research; and providing training and education in the theory and practice of scientific research.\(^{467}\)

The Western Australian Pregnancy Cohort (Raine) Study commenced in 1989 to produce a cohort of 3000 Western Australian children to be followed from early pregnancy up to at least 10 years of age. The primary aim of the study is "to investigate the relationships between events in pregnancy and outcome in childhood, and possibly adult life.\(^{468}\)

The pregnancy aspect of this study included very detailed assessment of the women, their partner and their pregnancy, followed by detailed examination of each child on the second day of life. Detailed questionnaires at 18 and again at 34 weeks gestation covered the woman's past history, lifestyle, environmental exposures, socio-economic conditions and size. Overall the database includes 1,100 items on each pregnancy.


\(^{468}\) Clinical Professor John Newnham. Correspondence to the Committee, 25 November 1994.
Many aspects of intervention in childbirth can be addressed by using the Raine database. Studies using the database which have been conducted include -

- description of growth disorder in those who received frequent ultrasound examinations;
- evaluation of the effectiveness of ultrasound tests;
- examination of the effects of exercise and occupation on pregnancy outcome;
- development of a screening test for the prediction of low-risk pregnancy;
- development of accurate growth charts suitable for the Australian population.

### 9.2.3 Institute for Child Health Research

The Institute for Child Health Research is actively involved in various research projects in the area of pregnancy and antenatal and postnatal care. It is also the home of the Maternal and Child Health Database that is referred to in Chapter Three, Section 3.2.5.

Researchers at the Institute for Child Health Research, in collaboration with the University Department of Paediatrics and the Obstetric team at KEMH, are following up the children from the Western Australian Pregnancy Cohort (Raine) Study. One component of the research will compare the weights of one year old children whose mothers received conventional or intensive fetal monitoring.

A study to test the accuracy of recall of information about pregnancy was linked to the Western Australian Pregnancy Cohort (Raine) Study and the results should be available later this year.

The Institute has been awarded a grant from Healthway to survey 10% of recently delivered mothers to collect data about many health issues - prepregnancy rubella immunity, folic acid supplement, low technology infertility treatment, smoking, alcohol, caffeine and recreational drug use, infant feeding practice and sudden infant death syndrome (SIDS).

The Ngunytju Tjitji Pirni (NTP) program of enhanced antenatal and postnatal care for Aboriginal women commenced in the Goldfields region of Western Australia in early 1993. The project has been developed to a stage where all the various parts have been well tested and are being consolidated. Health workers are successfully monitoring mothers and infants in the antenatal and postnatal periods. In addition, they are assisting Aboriginal families with access to medical and social personnel and are promoting healthy lifestyle practices. The NTP program is also discussed in Chapter Twelve.

Postgraduate students at the Institute are examining obstetric management of the third stage of labour and risk factors for antepartum haemorrhage.

### 9.2.4 Edith Cowan University School of Nursing

Postgraduate students at the School of Nursing at Edith Cowan University are involved with a number of research projects which are relevant to the Committee.

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Research topics which have or are being addressed include - comparison of primiparous women's expected and experienced pain in labour; childbirth expectations of primiparas 35 years and over in relation to their actual experience; the experience of homebirth from the perspective of parents; measuring midwives' accuracy of estimated blood loss during childbirth; and the relationship between episiotomy and perineal laceration and perineal pain following childbirth.

The Committee heard from witnesses and through informal discussions that obtaining money for research is becoming increasingly difficult.

**Recommendation:**

The State Health Budget must contain a separate program item for research funding because the only way to assess if there is any value or not in new technology is by proper research.

9.3 THE COCHRANE COLLABORATION

For many health professionals, policy makers and patients who want reliable information about health care procedures, it is unreasonable to expect them to find all the relevant evidence from reports of original research. These are far too numerous and dispersed to be of practical use. Therefore, they have had to rely on reviews of the primary research. Unfortunately, the poor quality of most reviews has meant that -

advice on some highly effective forms of health care has been delayed for many years, and that other forms of care have been recommended long after controlled research has shown them to be either ineffective or actually harmful.  

Over twenty years ago, Dr Archie Cochrane, a Welsh doctor, drew attention to the lack of knowledge about the effects of health care and how evidence from randomised controlled trials could lead to a more rational use of resources.

It is surely a great criticism of our profession that we have not organised a critical summary, by speciality or subspeciality, adapted periodically, of all relevant randomised controlled trials.  

As a result of this the Cochrane Collaboration has evolved. Contributors from many countries and specialties prepare and maintain systematic reviews of randomised controlled trials (RCTs), and reviews of other evidence. The Pregnancy and Childbirth Group is responsible for preparing an edited module of reviews - *The Pregnancy and Childbirth Module* - for incorporation in and then dissemination as part of the main *Cochrane Database of Systemic Reviews*. In addition, the group selects reviews from the main database for the *Cochrane Pregnancy and Childbirth Database*. The electronically published reviews are also used as a

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basis for preparing articles and books such as *A Guide to Effective Care in Pregnancy and Childbirth*. 472

In 1987, Dr Cochrane referred to the systematic review of RCTs of care during pregnancy and childbirth as "a real milestone in the history of randomized (sic) trials and in the evaluation of care". 473

The Committee heard from Professor Fiona Stanley and Dr Anne Read (8.2.95) about the benefits of the Cochrane Collaboration. This database should be used to provide health professionals and students with up-to-date information about current recommended obstetric practices.

The Cochrane Collaboration is about getting systematic, up-to-date reviews of research on the effects of health care into the public domain so that doctors can access it, midwives can access it, anyone can access it. Researchers can also access it so that they know what to research next. The data is essential, but not sufficient, for improving policy decisions in health care and research.

**Recommendation:**

The Health Department of Western Australia, hospitals and other organisations, which are responsible for developing policies for maternity services, should refer to the Cochrane Pregnancy and Childbirth Database to ensure the currency and accuracy of their information.

**Recommendation:**

The Cochrane Pregnancy and Childbirth Database should be made more widely available by the Health Department of Western Australia, to professionals working in the area of obstetrics in order that they can keep up-to-date with recommended best practice.

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RECOMMENDATIONS

Recommendation:

The State Health Budget must contain a separate program item for research funding because the only way to assess if there is any value or not in new technology is by proper research.

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The Health Department of Western Australia, hospitals and other organisations, which are responsible for developing policies for maternity services, should refer to the Cochrane Pregnancy and Childbirth Database to ensure the currency and accuracy of their information.

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CHAPTER TEN
MEDICO-LEGAL ISSUES

10.1 INTRODUCTION

The Committee has heard from all the doctors that the threat of being sued is a major concern for the profession and is cited as a reason why doctors are giving up obstetrics. The Defensive Medicine and Informed Consent Study conducted as part of the Review of Professional Indemnity found that specialty was significantly associated with whether or not doctors feel pressured by the threat of being sued. Eighty per cent of obstetricians and gynaecologists said they felt pressured by this threat. Fifty five per cent of obstetricians and gynaecologists reported having legal action taken against them whilst 42% reported having a complaint made against them. These -

rates of litigation and complaint may well deter individuals from entering obstetric and gynaecological practice and may discourage general practitioners, particularly those practising in rural and remote areas from performing obstetric procedures.

As discussed in Chapter Seven, from 1988-1992, the number of GPs in Australia who performed more than five private patient confinements (including caesarean sections) annually, had declined by 37.2%. Dr Keith Woollard (9.2.95) told the Committee although the cost of medical indemnity is a factor particularly for those doctors who perform a small number of deliveries, "the fear of litigation is the major problem for many of them [specialists]".

Researchers have shown that there is no guarantee that a woman will give birth to a perfect baby, regardless of all the precautions taken, and tests and technology used during pregnancy and childbirth. (This is discussed in Chapter Two, Section 2.3.1). Therefore, it is important that women are informed of these facts and that their expectations of pregnancy, childbirth and the outcomes are realistic.

The Commonwealth Department of Human Services and Health is conducting a review of professional indemnity arrangements for health care professionals entitled Compensation and Professional Indemnity in Health Care. Part of the review process involved the establishment of a Birthing Issues Sub-committee.


475 ibid. p 27.


10.2 PROFESSIONAL INDEMNITY

The Committee was hoping to refer to the Commonwealth Department of Human Services and Health's review of professional indemnity arrangements for health care professionals for direction in the area of professional indemnity. Unfortunately, the document was not released prior to this report being tabled. The Committee has been cautious in making recommendations in the area of professional indemnity in view of the forthcoming review.

10.2.1 Insurance by Employers

The issue of indemnity for salaried practitioners is a matter of major concern to the Associations and [medical] profession at large. The absence of certainty and support for practitioners who exercise their clinical judgement but may, in the course of their professional life, make an error of judgement which may lead to litigation is continuing to influence the way in which medical practitioners practice and their preparedness to undertake work on the Government’s behalf. 479

The Committee heard from the Australian Medical Association (WA Branch) (AMA[WA]) that there is currently no formal indemnification for salaried medical officers.

Indemnification was provided under a previous Public Service Board policy but lapsed with a change in the Government structure ... The Association [AMA] has been trying unsuccessfully to establish indemnification for salaried medical practitioners ... Some hospitals, both teaching and non-teaching, have relied upon previous assurances, however, there is presently no legal basis for that indemnification other than through implied common law contracts between the hospital and the practitioner. 480

The Health Department of Western Australia has prepared a draft Protocol for Cooperation in Litigation and Potential Litigation. 481

Under the protocol, doctors employed by the State, or the Board of State public hospitals including consultants, junior hospital doctors and general practitioners where these persons are in full-time, part-time or sessional employment are indemnified. In addition, residents, registrars and interns treating private patients in State hospitals at the direction of, or under the supervision of a consultant or other senior doctor are also indemnified.

However, there are a number of exclusions - such as employees of an incorporated medical practice or those who provide services on a contract for services/self-employed/fee for service basis.

The AMA (WA) has concerns about the protocol in relation to the definition of "misconduct", "which is totally unacceptable and requires major revision". 482 Mr Nigel McBride (26.4.95) pointed out that "the critical issue is, in what circumstances would the Government find a doctor’s

479 Submission 74 - Mr Peter Jennings, Deputy Executive Director, AMA.

480 ibid.

481 Health Department of Western Australia. Draft protocol. Protocol for cooperation in litigation and potential litigation.

482 Submission 74 - Mr Peter Jennings (quote from Dr Keith Woollard).
Select Committee on Intervention in Childbirth

behaviour was such that it would withdraw that indemnity? This has been a sticking point."

Mr Nigel McBride (26.4.95) told the Committee that there was concern that the protocol had "no contractual force and no force of law ... [it] can be withdrawn at any time" and "if they (doctors) are concerned there will be no backing, they will practice defensive medicine."

Following agreement amongst Queensland Health, the Australian Medical Association of Queensland (AMAQ) and other medical industrial groups, draft laws have been prepared which will -

indemnify all medical officers in the public hospital system treating public patients (even if they have been negligent) unless the person was guilty of criminal negligence, wilful misconduct or recklessness.

The Queensland Health Department provided the AMAQ with the following statement of policy -

Queensland Health (the "Crown") will indemnify all employees, members of Authorities, official committees and hospital auxiliaries, volunteers and other persons performing a duty or function for or on behalf of a Regional Health Authority provided the person has diligently and conscientiously endeavoured to carry out the duty or function.

It should be noted that a person can still diligently endeavour to carry out their duties or functions even if that person has been negligent, but not if such a person has been guilty of criminal negligence, wilful misconduct or recklessness.

The Crown will accept full and sole responsibility for all claims including the costs of defending or settling them and will not seek to exercise any claim for the contribution from the person provided that they have diligently and conscientiously endeavoured to carry out the assigned duty or function.

This indemnity applies to all employee specialist consultant medical staff but does not refer to other contractors or consultants.

This policy applies to all claims regardless of when they occurred.

The AMA(WA) "would urge prompt consideration of a similar approach to be adopted". The Committee supports this statement.

Recommendation:

The Health Department of Western Australia and the Australian Medical Association (WA) must resolve the indemnification issue for salaried medical practitioners.

Private practitioners are also not covered for practising outside the hospital, disciplinary tribunals and hospital disputes. They may not receive independent representation at coronial and medical

484 Submission 74 - Mr Peter Jennings.
10.2.2 Self Insurance

Medical defence subscriptions

The Select Committee on Professional and Occupational Liability 1994 received submissions that there has been an increase in the cost of medical defence indemnity coverage, increasing in the order of 30% a year.

The worst hit area is obstetrics where the cost is increasing to a point where many practitioners are questioning the wisdom of specialising in that area of medicine.

The Committee heard from many witnesses that the dramatic increase in medical defence subscriptions over the past few years (Figure 8) is one of the reasons for the decline in the number of doctors who wish to practice obstetrics. Specialist obstetricians currently pay about $25,000 per year and GP obstetricians pay approximately $5,000 per year.

The cost of medical defence premiums for those offering obstetric care, and the lack of availability and limitations on size of professional indemnity cover for midwifery practitioners, may be adversely affecting access to maternity care in a number of ways including: discouraging specialists from providing obstetric care; discouraging GPs from offering obstetric services; limiting the availability of obstetric care in rural and remote areas; hindering the development of alternative models of shared care and midwifery-based care, including the granting of hospital privileges to visiting midwives; and the prohibitive cost of providing cover for midwives, which may mean that the available insurance is not sufficient to meet potential future awards for neurological damage.

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485 Medical Defence Association of WA (Inc). Guidebook to membership and application form.

486 Select Committee on Professional and Occupational Liability. Legislative Council of Western Australia 1994.

FIGURE 8
The Australian Bureau of Statistics (ABS) undertook a survey of the medical defence organisation (MDO) industry and revealed that -

the dramatic increase in subscription rates since 1988 did not appear to relate to any new acceleration in claims frequency nor in dramatic increases in total amounts paid in respect of successful claims for damages. Rather it appeared to relate to moves away from a single common contribution rate towards speciality "risk rating" and to attempts to improve the level of funding of past liabilities. This later need arose because in the late 1970s and 1980s the frequency and size of claims increased dramatically and subscriptions were kept low for too long.488

The ABS survey also showed that -

the total subscription income in the MDO industry increased by more than 50% in the last two years, 1989 to 1991. It seems likely that per member subscription rates have been increasing in recent years in an effort to improve the solvency position of MDOs.489

Walsh and Skinner (1994) stated that subscription rates -

should perhaps be required to fully fund the liabilities incurred throughout the period of exposure. This may well involve any regulatory framework in an independent assessment of required subscription rates by various medical specialities.490

The annual number of claims on Australian medical defence organisations is currently about 1,500 and the average claim size is thought to be between $30,000 and $50,000. In addition, there are costs for administration and legal expenses. The total subscription income of the MDO industry appears to be about $80 million per year.491

Mr Dominic Bourke (26.4.95) told the Committee "there are not many obstetric claims ... of the 300 files that I have at the moment, probably five are obstetric cases" and Dr Graham Smith (9.2.95) said "as far as the actual litigation itself is concerned, I think it is exaggerated".

One of the recommendations of the Report on Medical Professional Indemnity Arrangements is that the authors -

support a system where subscription rates are filed annually, accompanied by a certification that these rates fully fund the liabilities which are expected to be incurred during the year of coverage, according to the definition of coverage which is ultimately adopted.492


489 ibid. p 47.

490 ibid. p 14.

491 ibid. p 14.

492 ibid. p 95.
The report also discusses the issues of cross-subsidisation whereby -

members with a lower risk pay a higher than theoretical subscription, the excess being used to support the rate of higher risk specialties; the justification for this is that if the higher risk specialties (e.g. obstetrics) were charged the theoretical risk rate, the subscription would be so high that the existence of this specialty may be threatened.\textsuperscript{493}

The Committee heard from a number of witnesses that the increased subscriptions have meant that obstetricians are required to do more deliveries in order to pay for their insurance.

**Medical Defence Association of Western Australia Inc.**

The Medical Defence Association of Western Australia Inc. (MDA[WA]) is a member of the Confederation of Australian Medical Defence Organisations. According to the *Report on Medical Professional Indemnity Arrangements* "doctors are far more likely to participate in a scheme owned and managed by themselves and their peers, rather than by insurance companies".\textsuperscript{494}

The MDA (WA)'s membership comprises approximately 2,600-2,700 doctors in Western Australia.\textsuperscript{495} Members are covered by a discretionary fund which is governed by a council of 12 Western Australian medical practitioners. Doctors apply to the fund for indemnity and all claims are reviewed by a Cases Committee.

**10.2.3 Professional Indemnity for Midwives**

Evidence from overseas indicates that "suits against midwives are far less frequent than against obstetricians". The *Compensation and Professional Indemnity in Health Care* report felt that midwives should have professional indemnity.

An extremely low incidence of professional negligence and adverse outcomes should be reflected in lower premium levels, rather than negating the need for such cover in the small number of cases, which in this specialty can involve catastrophic disability and high levels of damages against the health practitioner.\textsuperscript{496}

Mr McBride (26.4.95) told the Committee that "the day is coming, as nurses have a raised clinical profile and they consider carrying their own insurance, when they will be defendants".

The Committee heard that some midwives in private practice in Western Australia are insured with the Hope Island Insurance Company. Independent midwives can pay for $5 million a year cover for legal fees, professional indemnity and malpractice. However, not all midwives are insured for that amount.

\textsuperscript{493} ibid. p 95.

\textsuperscript{494} ibid.

\textsuperscript{495} ibid. p 11.

\textsuperscript{496} Commonwealth Department of Human Services and Health. *Compensation and professional indemnity in health care*. 1994; p 255.
10.3 STRATEGIES ADDRESSING MEDICO-LEGAL ISSUES

The Committee has heard from witnesses about a number of schemes which have been used or considered to overcome medico-legal concerns.

10.3.1 No Fault Liability

In New Zealand, "compensation for medical misadventure is, in some instances, provided by the no-fault scheme provided under the supervision of the Accident and Compensation Corporation". It is a universal compensation system and is employer funded. The scheme appears to ensure that health professionals' premiums are very low and that many complainants receive compensation. However, the Committee heard criticism of the scheme that more individuals may receive compensation but the amount they receive is low and it may not be enough for some individuals to cover their costs.

Mr Nigel McBride (26.4.95) told the Committee that -

although on the face of it, a no fault compensation scheme looks good, because it is perceived to be user friendly, lawyer free, and low cost to the applicant, we found that the New Zealand scheme was not, for example, lawyer free ... Although people had access to it, it also led to enormous fraud ... It does not work for the consumers because they do not get much out of it.

It has been suggested on many occasions that the threat of civil liability and what it does would encourage doctors to take care and perform. It has been suggested that when it is removed completely by a no fault scheme, it could also affect the quality of the service.

Mr Dominic Bourke (26.4.95) told the Committee that -

my argument against no fault schemes is that I do not think society can afford them. In my view the better option is to arrive at a capped insurance system, so that expectations are not sky high.

10.3.2 Statute of Limitations

The Committee heard that an obstetrician (GP or specialist) -

may be sued for up to twenty five years after a delivery that he or she may not have had any control over and then be judged by the most expert standards in the land at the time of the trial [not the time of the delivery].

The Committee heard from many witnesses about the issue of Statute of Limitations. Dr Keith Woollard (9.2.95) told the Committee that -

there should be a clear time limit for most ... claims. It is difficult to make sure the rights of a newborn infant are protected, but it should be achievable and a much shorter time could be developed.

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498 Submission 12 - Dr Nick Bretland.
Dr Nick Bretland believed that -

the Government must legislate to control the length of time after a delivery for which the obstetrician is legally liable.

"Amendment to the law to accord with the usual seven year limitation period (or even slightly longer) would assist."

The Legislative Council of Western Australia's Select Committee on Professional and Occupational Liability 1994 recommended that the limitation period be six years from the negligent act. This recommendation is particularly important in order to prevent a case such as Dissidomino v Newnham.

Further recommendations were -

that there be consistency in national legislation with respect to the limitation period

and

that in order to preserve the rights of plaintiffs, the new statute of limitation period commence with respect to existing causes of action after a period of three years from the date of operation of the amendment to the Limitation Act.

The recommendations of the interim report *Compensation and Professional Indemnity in Health Care* aim to implement a nationally consistent statute of limitations for medical negligence cases.

The PIR [Professional Indemnity Review] recommends that the option of an Australia-wide statute of limitations of three years for medical negligence cases be discussed with State Governments, medical defence organisations and health consumers, and that in the case of minors or people under a legal disability, the option that there be an absolute limit of six years from the date of injury on the commencement of an action, be explored.

According to Mr Dominic Bourke (26.4.95) -

in any baby case, the parents, on behalf of the child, should be able to get legal advice within a six year period that they either have or do not have a case. A requirement should be that the opposing party be put on notice that a claim will be made. If cases are left 25 years, people die, memories fade and documentation is destroyed.

Mr Peter Forbes (26.4.95) told the Committee that at the invitation of the Hon. Max Evans, when

499 Submission 12 - Dr Nick Bretland.
500 Submission 35 - Osborne Division of General Practice Ltd.
501 Select Committee on Professional and Occupational Liability. Legislative Council of Western Australia. 1994.
503 Select Committee on Occupational and Professional Liability. Legislative Council of Western Australia. 1994; p 8.
he chaired the Select Committee on Professional and Occupational Liability, the MDAWA and the AMA (WA) tabled a draft Medical Injuries Bill which put forward a proposal which could "lead to a stabilisation in relation to the Statute of Limitations for medical injury claims".

10.3.3 Capping of Claims

The Committee heard evidence that there needs to be some form of restriction on the amount of compensation received as a result of a claim for negligence.

Dr Nick Bretland (9.2.95) stated that -

the Government must legislate to control the amount of damages payable where an obstetrician is found negligent.

Dr Keith Woollard (9.2.95) told the Committee -

we believe some form of capping is needed, simply to provide guidance to the courts ... The courts need guidance on what the community at large or the Parliament thinks is an appropriate level of compensation.

Mr Nigel McBride (26.4.95) felt that -

if statutory capping occurred, there would not be quite the same incentive to pursue litigation, depending on what the capping was ... Given the high cost of common law and lawyer’s fees, statutory capping would mean statutory obliteration of claims ... On the other hand, there is some concern that consumers who are genuinely wronged ... [would] find it very difficult now to bring an action.

10.3.4 Structured Settlements

Mr Peter Forbes (26.4.95) told the Committee that -

from the medical defence organisation's point of view, the issue which has the greatest input of funding is the after care costs ... The strong recommendation that was made by the various medical defence organisations to the Tito committee was that there needed to be structured settlements in Australia. That is where funding would be made available for the injured during his lifetime, and lump sum payments would not be made, resulting in windfalls.

In evidence presented to the Select Committee on Professional and Occupational Indemnity, Mr Peter Forbes commented -

in that country [US], rather than a defense (sic) fund, for example, paying $2.5 million for a neurologically impaired child, it will buy an annuity for the family, or whoever, to look after that child. If the child dies at the age of seven or eight, the benefactors do not become the parents, the liability stops at that point of time.

The Committee heard evidence from Dr Dale Evans (9.2.95) that -

we have applied for what we call a structured settlement whereby instead of getting a lump sum they simply get an annuity and if the child dies, or whatever, in the future then that lump sum is returned to the general revenue to be recycled. That would have an enormous effect on the premiums. That is the simplest way to go without capping, or even without going into ... other things, because 70% children who have major settlements die within two years.
The attractiveness of the structured settlement option may be questionable under the current taxation arrangements. "Lump sum payments are non-taxable. However, periodic payments are taxed as normal income."\textsuperscript{505} The interim report on \textit{Compensation and Professional Indemnity in Health Care} made the following recommendation -

\begin{quote}
that appropriate tax law amendments be investigated, or that the law be clarified, to ensure that the current incentives to take an undifferentiated lump sum compensation settlement are minimised and the incentives to use periodic payment arrangements are maximised.\textsuperscript{506}
\end{quote}

The Committee heard from Dr Keith Woollard (9.2.95) that "structured payments are a clear way of reducing the magnitude of the payout. There should be a limitation on awards for non-quantifiable elements of the payouts."

The Committee sees structured settlements as the fairest way to ensure that a child receives the benefits.

\begin{center}
\textbf{Recommendation:}
\end{center}

\begin{quote}
The issue of "structured settlements" should be closely examined by the Western Australian Government.
\end{quote}

\subsection*{10.3.5 Other Strategies}

"Perhaps pregnant women should insure their own pregnancies like we insure our own cars, to spread the burden of litigation."\textsuperscript{507} The Committee does not believe that this is an appropriate course of action.

\subsection*{10.4 OBSTETRIC RESPONSIBILITY}

The issue of who takes responsibility for obstetric procedures was discussed. "An obstetrician, whether general practitioner or specialist, is held legally responsible for the actions of other carers, even though he or she may have no control over that individual."\textsuperscript{508}

\begin{itemize}
\item \textsuperscript{505} Mr Peter Forbes. Evidence to the Committee 26.4.95.
\item \textsuperscript{506} Commonwealth Department of Human Services and Health. \textit{Compensation and professional indemnity in health care}. 1994: p xxiii.
\item \textsuperscript{507} Submission 63 - Dr Norman Gage.
\item \textsuperscript{508} Submission 12 - Dr Nick Bretland.
\end{itemize}
Ms Caroline Flint (29.3.95) told the Committee that -

as a European midwife, I am a practitioner in my own right. I am completely responsible for taking on the care of women during childbirth so I do not need to refer ... women to a doctor ... but in the case of any illness or abnormality of the mother, fetus or baby I must summon to my assistance a registered medical practitioner.

Ms Enid Facer (16.2.95) explained that the situation is different in Western Australia. Independent midwives in Western Australia -

always work with a doctor. We consider we are the primary care giver ... The doctor is the expert in abnormal pregnancies and if there is a problem, we refer the women to the doctor.

In England, midwives are able to order required blood tests for women while in Western Australia, only doctors are permitted to request the tests.

The division of responsibility is a "grey" area. It appears if there is a case of negligence the court would examine the facts to determine where the problem occurred. However, the Committee did hear that there is a tendency to sue the doctor or hospital because they are perceived to have more money.

As discussed in Section 10.2.3, midwives in private practice can apply for their own professional indemnity.

The Committee believe the area of responsibility is very important. The reader should refer to Chapter Seven which examines the roles of the different professionals in the area of obstetrics.

**10.5 INFORMED CONSENT**

There is a community recognition that patients are entitled to make their own decisions about their medical treatment. These decisions will need to be based on information and advice given by the doctor.

In 1989, the Law Reform Commissions of Australia, Victoria and New South Wales recommended that the National Health and Medical Research Council (NHMRC) formulate guidelines for the medical profession about providing information to patients about proposed treatment and procedures. Following consultations and the handing down of the judgement in Rogers and Whitaker (1992), the NHMRC document *General Guidelines for Medical Practitioners on Providing Information to Patients* was issued in 1993 and covers the type of information which should be given to patients. In particular, there is a need to give information about benefits, potential risks, and the possible cascade effect of a proposed medical intervention. Also the manner in which information should be given and circumstances where withholding information may be justified is included.

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Mrs Sue Terry\textsuperscript{511} suggested that research-based education and responsible legal advice to the public would do much to reduce the litigation cost spiral which is forcing up insurance premiums.

The Committee heard from Ms Joan Greenwood (8.8.94) that "informed consent of women to procedures may not mean more intervention". She also said that -

if women gave more informed consent, they might feel they were in charge and made the choice. They might then not feel it must be something somebody else did that has gone wrong.

The Committee is convinced that women need to be fully informed about their options for maternity care and that this should occur during the antenatal period. Chapters Two and Eleven provide additional information.

\begin{quote}
\textbf{Recommendation:}

All doctors should have a copy of the booklet "General Guidelines for Medical Practitioners on providing information to Patients". They should be aware of the contents and the significance of the said document.
\end{quote}

\section*{10.6 CONCILIATION SERVICE}

Dr Woollard (9.2.95) told the Committee "the AMA strongly supports the concept ... of a conciliation service dealing with these issues and preventing them getting into the legal sphere".

"There needs to be a forum where concerns regarding management by obstetricians and GPs can be expressed and acted upon."

Complaint mechanisms for health consumers are outlined in \textit{Compensation and Professional Indemnity in Health Care}. Most States, with the exception of Tasmania, the Northern Territory and Western Australia, have a formal state-wide complaints body. Several States have a statutory basis for these bodies and Western Australia expects to introduce legislation in the near future. The 1993-98 Medicare Agreements provide for some consistency in that all States are to establish a complaints body which must -

\begin{itemize}
\item be independent of State hospitals and the State Health Department;
\item have powers to investigate, conciliate and adjudicate on complaints received; and
\end{itemize}
be given a role in recommending improvements in the delivery of services in respect of which the Commonwealth provides financial assistance. 513

The intention of the complaint mechanisms appears to be -

to resolve the grievance as informally as possible, especially where a breakdown in communication between the health care professional and the patient has occurred, and to use powers conferred by legislation only where necessary, for example, where there may have been a breach of professional standards or professional misconduct. 514

The Committee heard that the Western Australian Government "would introduce legislation in the next Parliamentary session to establish a body to deal with health complaints" and according to the Hon. Graham Kierath, Minister for Health, "the Government recognises the need for an identifiable focus for complaints and to enable more accountability of health services". 515

**Recommendation:**

The Committee supports the move by the Western Australian Government to introduce the Health Services (Conciliation and Review) Bill 1995 during the current Parliamentary session.


514 ibid. 1994; 176.

515 Media Statement from the Hon. G Kierath MLA, Minister for Health; Labour Relations. 8 August 1995.
RECOMMENDATIONS

Recommendation:

The Health Department of Western Australia and the Australian Medical Association (WA) must resolve the indemnification issue for salaried medical practitioners.

Recommendation:

The issue of "structured settlements" should be closely examined by the Western Australian Government.

Recommendation:

All doctors should have a copy of the booklet "General Guidelines for Medical Practitioners on providing information to Patients". They should be aware of the contents and the significance of the said document.

Recommendation:

The Committee supports the move by the Western Australian Government to introduce the Health Services (Conciliation and Review) Bill 1995 during the current Parliamentary session.
CHAPTER ELEVEN

EDUCATION PROGRAMS

11.1 INTRODUCTION

The Committee examined a number of areas of education which do or could address the issues of pregnancy and childbirth. These include educating children and adolescents about the issues and giving them the opportunity to make informed choices later in life. Broad based community education is also an important avenue for providing accurate information about childbirth options and allowing members of the community to examine their attitudes and expectations. Preconceptual, antenatal and postnatal education are vital to women and their partners so that they can make informed choices and they can develop realistic expectations about their pregnancy and childbirth, and parenting.

11.2 SCHOOL BASED EDUCATION

A number of witnesses felt that options for childbirth should be discussed at school. "There should be a proactive approach to portraying childbirth as a normal process using the school curricula." There is an opportunity to overcome the stereotype that all mothers go to the traditional labour ward to have their babies. It would also provide the opportunity to give young women the confidence that pain can be managed through non-drug methods.

11.2.1 Human Biology

Currently, the Year 11 Human Biology syllabus is divided into two sections, each containing core and non-core material. The non-core material is considered to be enrichment material which will enhance students' understanding of the core content. The "Continuity of the Human Species" section contains information about pregnancy and childbirth. The core content includes prenatal care; signs and symptoms of the birth process; changes to mother and child during birth; postnatal care; and the non-core content includes natural birth, induction, breech; caesarean, Leboyer, home and hospital births, defects due to abnormal birth, ultrasound and other testing.

11.2.2 Health Education

Health education is not a compulsory subject but it is taught in the majority of State primary and secondary schools. The K-10 syllabus is very comprehensive. Teachers select what is relevant to their pupils. There are currently no plans to update the syllabus.

Pregnancy and childbirth are addressed at various stages of the K-10 health education syllabus within the emotional and mental health and societal health issues strands.

In Year 3, students discuss the growth of a baby and its emotional and physical needs before and after birth.

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516 Submission 41 - Mrs Sue Terry.
In Year 4, children discuss conception, birth and nurturing of a baby and they learn to use appropriate vocabulary.

In Year 7, children discuss conception, pregnancy, birth and parenting responsibilities.

In Year 10, children evaluate the influence of the media on images and beliefs about parenting and they identify that many pregnancies are unplanned and discuss the personal and societal implications. They also survey and discuss current health issues such as in vitro fertilisation.

**Recommendation:**

The Health Education Syllabus in schools should ensure that emphasis is placed on low intervention, natural birth. In addition, school children must be given a balanced view of childbirth options. There should be more opportunity for community groups representing a wide range of these options to give talks to school groups.

**11.2.3 Home Economics**

In personal and vocational education, Child Development 5.3, students are involved in a variety of activities which will require them to -

- identify the symptoms of pregnancy;
- briefly state the physical changes that take place in a mother's body during pregnancy;
- explain the importance of prenatal care for the mother-to-be and the developing fetus;
- describe the stages of the birth process.

Early childhood studies, part of the home economics course, is an optional unit which is taught in Year 11 and 12. In Year 11, students address information on pregnancy and childbirth. The input from teachers will depend very much upon their own knowledge and experience.

The Year 11 early childhood studies course is divided into two sections - *The development of children from conception to 5 years of age* and *The needs of children from birth to 5 years of age*. Two of the course objectives which relate directly to the Terms of Reference of the Committee are that students should be able to -

- discuss how the roles, attitudes and responsibilities of family members change during pregnancy and following the birth of a child;
- outline the birth process.

The course content includes preparation for pregnancy, birth and parenthood; antenatal and postnatal care of the mother; and stages of the birth process.
11.3 COMMUNITY EDUCATION

Community education about options for childbirth, and examination of the community’s expectations and attitudes towards childbirth is very important. These issues are also addressed in Chapter Two. Many submissions and witnesses were in favour of increased community education.

Dr Keith Woollard (9.2.95) told the Committee that in order to influence community expectations -

we shall need a relatively expensive public education campaign to let the community know what is a reasonable expectation for obstetric services, to encourage them to seek their care from GPs. That would receive widespread support from the medical profession, including obstetricians.

11.3.1 Community Education Strategies

During its lifetime, the Committee became aware of some events which were aimed to draw attention to different options for childbirth.

Education sessions

King Edward Memorial Hospital for Women, through its Staff Development Centre, conducts monthly education sessions for members of the public on a variety of topics relevant to women's health.

The Parents, Babies and Children's Show

The second Parents, Babies and Children's Show was held in Perth from 7-9 April 1995. It was an avenue for hospitals, professional and community groups to promote the services they offer and for members of the public to obtain information about different options for childbirth.

International Day of the Midwife

Friday, 5 May 1995 was the International Day of the Midwife. In 56 countries, midwives and mothers united to bring the world's attention to the need for more midwives. In Western Australia events were organised by the Australian College of Midwives (Inc) (ACMI). These included displays in Perth by professional and community-based groups, events at metropolitan and regional hospitals and press coverage.
Recommendation:

The Health Department of Western Australia should conduct a campaign and provide funding to selected consumer education groups to raise public awareness about the different models for maternity care available to women and to address community attitudes and expectations as part of public health.

11.4 PRECONCEPTUAL EDUCATION

A number of witnesses felt that preconceptual education would be a useful strategy. Women of childbearing age and their partners should be targeted with information about different options for antenatal care and childbirth. There are currently a number of health programs that address the needs of young women contemplating pregnancy to consider their health behaviours, e.g. they are being encouraged to reduce the amounts of alcohol they consume, to increase the folate levels in their diet, to give up smoking in the first three months of pregnancy and to ensure they are immunised against rubella. "Preconceptual health counselling could be better explored to reduce the risks associated with poor health from the beginning of pregnancy."\(^{520}\)

Preconceptual clinics [should be] run by midwives with multidisciplinary back-up support, working from the onset to correct/prevent the multiple issues which drive couples in the current delivery system to demand intervention.\(^{521}\)

Recommendation:

The aforementioned Health Department campaign should target women of childbearing age and their partners to raise their awareness about the need to prepare for pregnancy, and about the different options for antenatal care and childbirth available in Western Australia and to address their attitudes and expectations.

11.5 ANTENATAL EDUCATION

The Committee heard from many witnesses that there is a need to educate women about pregnancy and childbirth in order that they can make informed choices about their care.

The *Survey for Mothers*\(^{522}\) found that just over half of the women (55%) attended antenatal classes. Most of those who attended (87%) were first time mothers. Most of the classes (81%) took place in a hospital. Classes were also provided by midwives at the Family Birth Centre (9%), community health centres (6%) and by private midwives (3%). Classes were most commonly given by midwives (51%), physiotherapists (36%) and child health nurses (9%).

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\(^{520}\) Submission 43 - Ms Janice Butt.

\(^{521}\) Submission 66 - Mr Patrick O'Donaghue.

11.5.1 Availability

In Western Australia there is no formal antenatal education program although many antenatal classes are conducted in the community and in many metropolitan and country hospitals.

King Edward Memorial Hospital for Women offers a large range of free parent education programs which are conducted by midwives, often in conjunction with other professionals. These include early pregnancy discussions, a series of six childbirth and parenting talks on topics such as labour, pain relief and when to come to hospital, delivery of the baby and early care, and discussion of different types of deliveries. There are additional talks on pain relief options for labour delivery and caesarean section (with an anaesthetist and a midwife). Tours of the hospital are conducted several times each week. Physiotherapists also conduct preparation for labour classes, healthy pregnancy aerobic classes and postnatal classes.

Private hospitals such as St Anne's Mercy Hospital, St John of God Hospital, Glengarry Hospital and Attadale Hospital offer antenatal education classes. At some hospitals, women are recommended to attend the "Early Birds of Pregnancy" program as soon as possible after pregnancy is confirmed. Free classes on labour, delivery, neonates, breastfeeding and parenting are conducted by midwives and women are recommended to attend these at about 28-30 weeks gestation. Some hospitals offer refresher courses for couples who have already had a childbirth experience. Hospital tours and physiotherapy classes (for which a fee is charged) are also available.

Antenatal classes are also available in the community. Fremantle Community Midwives offer Natural Childbirth Classes for women and their support people. They conduct a series of three early bird classes and three late pregnancy classes. The Midwifery and Natural Childbirth Centre also offers a range of services including childbirth preparation classes. Some antenatal classes are run privately and the cost of the classes depends upon the number of people enrolled.

The Expert Maternity Group in the UK stated that -

women should be fully involved when decisions are to be made about their care ... They should be kept fully informed on matters relating to their care; and

women should receive clear and unbiased advice and be able to decide where they would like their baby to be born.

I have a deep concern that the sole focus on the physiological elements of birth can and do contribute to women having more difficult labours ... the majority of information is detailed in terms of objective processes and procedures and we are not encouraged to entertain the idea that birth might be much more than a physiological process.

In 1985, the NHMRC Working Party to Investigate Variations in Caesarean Section Rates in

523 Pers. comm: Ms Margaret Mazzuchelli, Health Department of Western Australia.

524 Department of Health. Changing Childbirth. 1993; p 76.

525 ibid. p 78.

526 Submission 15 - Ms Linda Rawlings.
Australia believed that -

the inappropriate expectations of parents may increase pressures on obstetricians for intervention and rapid delivery. Improved education for parents and prospective parents should be encouraged, with particular attention to the following areas -

(i) the nature of normal labour;
(ii) management of complications;
(iii) indications for repeat caesarean section. 527

Mrs Henny Ligtermoet (27.4.95) raised the issue about who should deliver antenatal education -

antenatal education ... should not be under the guidance of the medical profession ... A person trained in the medical profession is trained in a negative way.

Preparation for parenthood

The Health Department of Western Australia has produced a Preparation for Parenthood program. 528 These classes are conducted by Community Nurses from the Health Department of Western Australia.

Information about procedures in hospitals

Mrs Henny Ligtermoet mentioned "the difficulty that mothers have to obtain statistics from various hospitals. They should be freely available so that women can indeed make that informed choice." 529

11.5.2 Reasons for Not Attending Antenatal Classes

According to the Survey for Mothers, 530 the main reason given by women for not attending antenatal classes was that they had already experienced a previous pregnancy (51%). Some women (15%) felt the classes would not have helped.

The Committee heard from witnesses that the reasons that Aboriginal women and teenage women do not attend classes may be because the classes are not appropriate for them.

11.5.3 Suggestions for Improvements to Antenatal Education

Findings from the Survey for Mothers 531 are included in Table 12, Appendix B. Of the women who responded, 27% did not think that the classes could be improved in any way. Overall, 42%


529 Submission 30 (supplement) - Mrs Henny Ligtermoet.


531 ibid. p 12.
of women wanted more emphasis on birth and motherhood and 10% asked for more teaching about breastfeeding.

**Recommendation:**

Antenatal education services must be reviewed and targeted with the objective of developing services which are more appropriate to Aboriginal women, low income earners, teenage women and multicultural women. Programs should emphasise the importance of encouraging their involvement. The Committee does not support the idea of a centralised, standardised antenatal education program.

**Recommendation:**

The Health Department of Western Australia, in thorough consultation with community education groups, must produce a booklet for pregnant women or women of childbearing age and their partners which outlines the different models of maternity care, philosophies, and procedures practised at individual hospitals, birthing units, the Family Birth Centre or for home deliveries which would help women to decide where they would like to have their baby. The booklet should also include the names of all currently practising community midwives, GP obstetricians and specialist obstetricians in order to allow mothers to approach them for further information. Funding for this project could come from Healthway or the Lotteries Commission.

### 11.6 POSTNATAL EDUCATION

Postnatal groups provide women with the opportunity to share their birth experiences and to obtain support during the first few months after the birth of a baby which may be a very stressful time for women.

The *Survey for Mothers* found that only 12% of women surveyed attended postnatal classes. A higher proportion of elderly primiparas (26%) attended compared to other groups and private patients were twice as likely as public patients to attend. Thirty three per cent of women were not aware of the existence of postnatal classes.

Many hospitals offer postnatal classes. King Edward Memorial Hospital for Women conducts a range of postnatal classes. Postnatal reunions are held at some hospitals as an informal gathering for new parents. Postnatal care and support is also available through community groups.

In 1993, the Health Department of Western Australia produced the *Postnatal Parenting Package*, a 6-7 session program which has a number of objectives.

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532 *ibid.* p 50.
At the conclusion of the course, participants should be able to -

- demonstrate levels of confidence and satisfaction with motherhood/fatherhood and infant care;
- have realistic expectations of the parenting role and infant care;
- discuss expectations of their infant's behaviour consistent with developmental age;
- demonstrate awareness of community resources which are available to help with different aspects of the parenting role;
- establish informal support networks with other participants which will continue after the completion of the postnatal parenting program.  

The package can be adapted and presenters can supplement the program with other information.

Debriefing

As mentioned in Chapter Five, it is important to allow women to debrief their birth experiences.

Recommendation:

Women must be encouraged to attend postnatal sessions after they leave hospital and to take the opportunity to debrief their birth experience. This is particularly important for women who have had intervention such as an operative delivery.
RECOMMENDATIONS

Recommendation:

The Health Education Syllabus in schools should ensure that emphasis is placed on low intervention, natural birth. In addition, school children must be given a balanced view of childbirth options. There should be more opportunity for community groups representing a wide range of these options to give talks to school groups.

Recommendation:

The Health Department of Western Australia should conduct a campaign and provide funding to selected consumer education groups to raise public awareness about the different models for maternity care available to women and to address community attitudes and expectations as part of public health.

Recommendation:

The aforementioned Health Department campaign should target women of childbearing age and their partners to raise their awareness about the need to prepare for pregnancy, and about the different options for antenatal care and childbirth available in Western Australia and to address their attitudes and expectations.

Recommendation:

Antenatal education services must be reviewed and targeted with the objective of developing services which are more appropriate to Aboriginal women, low income earners, teenage women and multicultural women. Programs should emphasise the importance of encouraging their involvement. The Committee does not support the idea of a centralised, standardised antenatal education program.
Recommendation:

The Health Department of Western Australia, in thorough consultation with community education groups, must produce a booklet for pregnant women or women of childbearing age and their partners which outlines the different models of maternity care, philosophies, and procedures practised at individual hospitals, birthing units, the Family Birth Centre or for home deliveries which would help women to decide where they would like to have their baby. The booklet should also include the names of all currently practising community midwives, GP obstetricians and specialist obstetricians in order to allow mothers to approach them for further information. Funding for this project could come from Healthway or the Lotteries Commission.

Recommendation:

Women must be encouraged to attend postnatal sessions after they leave hospital and to take the opportunity to debrief their birth experience. This is particularly important for women who have had intervention such as an operative delivery.
CHAPTER TWELVE

WOMEN AND GROUPS WITH SPECIAL NEEDS

12.1 INTRODUCTION

The Committee heard that there are a number of groups of women in the community who may have particular needs during pregnancy and childbirth. These needs may arise as a result of cultural, physical or emotional factors. The Committee received submissions and heard evidence from witnesses who addressed these areas.

12.2 MULTICULTURAL WOMEN

Western Australia is an increasingly multicultural society. Hence, women who are giving birth have different expectations and needs during pregnancy and childbirth. "The influences of cultural origins and mores must be taken into account when considering the planning of health services." 534

Women with specific cultural needs in relation to the place of birth and choice of caregiver are not catered for in the present system. This causes deep distress and shame among many migrant women who birth their babies in the Australian hospital environment amongst strangers who are unable to speak their language and who may be unacceptable to their culture and religion. These women are not provided with accurate, unbiased information in their own language. 535

The Committee heard from Ms Joan Greenwood (8.8.94) that -

we must respect people's cultures and beliefs ... Sometimes we tend to feel if they have come to live in our country they should behave as we do. Of course, with childbearing that is exactly what they do not want to do. They want their own rituals and cultures. 536

Of the women who gave birth to babies in Western Australia in 1991, 71.3% were born in Australia, 13.8% were born in the United Kingdom, 3.5% in New Zealand, 2.4% in Other Europe and former USSR (excludes Italy and former Yugoslavia), 2.0% in Other Asia (excludes China, India, Malaysia, Philippines and Vietnam), and the remainder were born in other countries. 537

In 1993, 7% of mothers in Western Australia were of races other than Caucasian and Aboriginal. 538 A study of a sample of these women indicated that over two-thirds of them were of Asian origin.

534 Submission 50 - Ms Anne-Marie Widermanski, et al.
535 Submission 11 - Ms C Cook, et al.
536 Evidence to Committee - Ms Joan Greenwood 8.8.94.
538 Health Department of Western Australia. *Perinatal Statistics in Western Australia*. 1993; p 7.
12.2.1 Services Available to Multicultural Women

The Multicultural Women's Health Centre in Fremantle was formed in 1985 by women in the Fremantle community to provide a gynaecological health service for women of all cultural backgrounds. In 1989, the centre started the "Mothers' Morning" program for pregnant women and women with infants and young children. It has been very successful and has grown to incorporate the needs of women suffering from postnatal depression. It includes antenatal and postnatal exercise classes, a postnatal support service, talks by guest speakers and the opportunity to speak to a midwife, child health nurse or clinical psychologist.

Preparation for birth classes have been discontinued because of lack of funding. The centre staff feel they are well placed to offer a comprehensive antenatal service to women from non-English speaking backgrounds and can also offer services after the birth of the baby. They feel continuity is important for women especially those who have difficulty accessing a broad range of community services because of language, cultural and transport barriers.

The centre has applied to the Alternative Birthing Services Program to fund a project with four complementary service streams -

- antenatal education for women with special needs;
- alternative birthing services - home and Domino birth;
- provision of information;
- bilingual or bicultural workers.

Antenatal Services at King Edward Memorial Hospital for Women, include parent education classes with a special session for migrants with limited English skills.

**Recommendation:**

Health professionals must be better informed about the specific needs of different cultural groups and know where to obtain relevant information.

**Recommendation:**

Women from different communities must be actively consulted about any particular cultural needs of their communities in relation to pregnancy and childbirth.

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539 Submission to the Alternative Birthing Services Program by the Multicultural Women's Health Centre, Fremantle.
12.3 ABORIGINAL WOMEN

12.3.1 Statistics

In 1993, Aboriginal women comprised 5.7% of mothers.\textsuperscript{540} As indicated in Chapter Three, the perinatal and maternal mortality rates for Aboriginal women are higher than for non-Aboriginal women.

Intervention rates

Aboriginal women appear to have less intervention. There appears to be no great variation in the emergency caesarean rates between Aboriginal and non-Aboriginal women but the rate of elective caesarean section is twice as high for non-Aboriginal women compared to Aboriginal women. The Committee heard that the reasons for the reduced rates are unclear and it would be hard to determine statistically because of the small numbers of women giving birth.

12.3.2 Committee's Visit to Kalgoorlie

As part of its investigations, the Committee spent two days in Kalgoorlie and consulted with health professionals, representatives from Aboriginal groups, and members of the public. The report on the Committee's visit can be found in Appendix A.

Cultural birthing centre

During the Committee's visit to Kalgoorlie they had many discussions about the proposal to establish an Aboriginal Birth Centre at Kalgoorlie Regional Hospital. The Committee supports the view of many witnesses that adequate community consultation is essential.

The Committee was told about the Alukara, an Aboriginal women's community-controlled health and birthing centre which was officially opened in the Northern Territory in October 1994.

\textbf{Recommendation:}

Full consultation with the Aboriginal community (families, mothers, opinion leaders), obstetricians, GPs, midwives, and traditional carers, over a 6-12 month period, must take place before a cultural birthing centre could proceed.

12.3.3 Needs of Aboriginal women

Women's needs

On 19 July 1995, all female staff of the Perth Aboriginal Medical Service were invited to attend

\textsuperscript{540} Health Department of Western Australia. \textit{Perinatal Statistics in Western Australia}. 1993; p 7.
a workshop to identify issues and share ideas about pregnancy and childbirth. Twenty Aboriginal women (17 had experienced childbirth) participated in the final selection of priorities in childbirth. Each woman was asked to contribute the three most important things she would like, or which she thought were important for metropolitan Aboriginal women during the antenatal, intrapartum and postnatal periods. The women were then invited to choose the five ideas they thought were the most important from all the ideas suggested. The main priorities, in order of popularity were -

- education about labour options/choices/different modes of delivery (eg; caesarean with or without epidural; to be asked what they want;
- grassroots antenatal and breastfeeding information (that is information from specially trained non-medical people such as health workers or breastfeeding counsellors);
- antenatal clinic at PAMS and money for field workers to bring women in to the clinic;
- antenatal education available at PAMS including nutrition of mother, medical, social and infant care and nutrition;
- to be treated with respect as an individual responsible person during labour and delivery;
- PAMS to have at least two Triple Certificate Registered Nurses (general, midwifery and child health) on staff who would take part in antenatal and postnatal clinics and education and liaise with maternity units (also involved in home visiting);
- education about sex, antenatally and postnatally;
- Aboriginal health workers' midwifery course in Western Australia with pay for time spent during the course;
- continuity of care in labour (same attendant throughout);
- advocate/educator available in labour ward;
- support people (partner, female relatives, friends) during labour and delivery.

According to Hilda Bastian (1993), Aboriginal women were not consulted in the original development of services and their knowledge has not been utilised. Consistent themes have emerged from consultation with Aboriginal communities about meeting women's needs around childbearing. The following recommendations were seen as key requirements for improving levels of intrapartum care and support -

- promotion of antenatal, postnatal and new baby care through Aboriginal Health Services, supported by health education programs in family planning, nutrition, pregnancy care, breastfeeding and immunisation;

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541 Submission 75 - Dr Sandra Eades, Perth Aboriginal Medical Service.

increased availability of health worker support for traditional community birthing;

establishment of culturally appropriate Aboriginal birthing centres for women at low-risk of complications.

The Committee heard that Aboriginal women are not receiving much antenatal education, they are late presenters, they have their first babies at an early age and they have large families. Culturally, they cannot acknowledge to themselves that they are pregnant and must wait for someone else to acknowledge their pregnancy. While non-Aboriginal women experience the final weeks of pregnancy with great excitement, "most Ngaanyatjarra women feel a deep sense of shame simply by having to publicly acknowledge their pregnancy". 543

According to Linda Rawlings, in contrast to the western experience, women in traditional and indigenous cultures -

had a very different sense of expectancy in relation to the process of birth ... No formal preparation for the birth beyond ritual and sacred processes was required.

For Australian Aboriginal women who continue to birth in the traditional way, the land upon which the child is born is significant.

**Leaving the land**

For the past 20 years Aboriginal women have been sent to regional hospitals to give birth in an attempt to reduce the infant mortality statistics. Women may leave their communities as early as 36 weeks and then have to wait in regional hostels or hospitals for up to eight weeks. The waiting can lead to intense loneliness and fear, separation from the land and family support. 544

**Antenatal care and education**

Many Aboriginal women are not receiving antenatal education. The Committee heard that Aboriginal women would be more comfortable going to a class run by an Aboriginal antenatal educator.

The Ministerial Review in Birthing Services in Victoria *Having a Baby in Victoria* 545 recommended that -

- culturally appropriate and accessible antenatal classes for Aboriginal women be established. Antenatal classes should cover areas related not only to the antenatal period and confinement, but also the postnatal stage with particular emphasis on breastfeeding and care of the newborn and older children.

The Committee heard informally from Marion Kickett, of the Marr Mooditj Foundation Inc., that there is a need to have a program to train Aboriginal Health workers how to run antenatal clinics.

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543 Submission 15 - Ms Linda Rawlings,

544 Submission 15 - Ms Linda Rawlings. Article in *Medical Observer*.

She felt Aboriginal women would be more inclined to go to antenatal classes if they were run by Aboriginal women.

Only a small number of Aboriginal women (24) responded to the *Survey for Mothers* \(^{546}\) and only a third of them responded to a question about suggested improvements in antenatal care (Table 11, Appendix B). Two women requested more respect from staff and three requested more time from staff. Only three Aboriginal women made suggestions for improvements of antenatal classes. These included - breastfeeding, emotional adjustment and aspects of motherhood (Table 12, Appendix B).

During the Committee's visit to Kalgoorlie, members met with representatives from the Ngunytju Tjitji Pirni program which provides antenatal care and postnatal care for Aboriginal women. It is also referred to in Chapter Nine, Section 9.2.3.

### 12.3.4 Education of Health Providers

The Committee heard that health professionals working with Aboriginal communities should be given the opportunity to learn about Aboriginal culture. Bastian (1993) states there is a "need for more education of perinatal health care providers in the broad range of Aboriginal women's needs, values, cultural experiences and traditions". \(^{547}\) She also refers to the need to inform Aboriginal women of possible and proposed procedures and the availability of interpreter services and personal support.

**Recommendation:**

Health professionals offering maternity services for Aboriginal women and their families, and other hospital employees who come into contact with Aboriginal people must be given the opportunity to learn about Aboriginal culture.

### 12.3.5 Health Worker Training

Training of Aboriginal health workers is carried out at the Marr Mooditj Foundation Inc. Students enrol for the Advanced Certificate course (one year). This is a prerequisite for other courses. If they score an average of 75% or more for all the units within the Advanced Certificate course, they can enrol for the Diploma in Aboriginal Health (one year). As part of the Advanced Certificate course, students must attend a compulsory two day workshop at King Edward Memorial Hospital for Women where they address antenatal care, birth and postnatal care. They also study anatomy, physiology and human biology at the Foundation. There is an optional four week maternal health unit as part of the Diploma course. Diploma students do two weeks of theory at the Marr Mooditj Foundation and two weeks of practical training at Kalgoorlie Regional Hospital.

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\(^{547}\) Bastian H. 1993; p 572.
There are currently 80 students at the Foundation. Thirty students are doing the Diploma course, 15 are studying for the Advanced Certificate on a full-time basis, and 35 are studying for the Advanced Certificate on a part-time basis. Trainees from the country can do the course by coming to Perth for two week blocks of study. The course has been adapted for the needs of the students.

In addition to maternal health, Advanced Certificate students have a two week course on child health (newborn to five years of age) which is presented by a child health nurse.

In July 1995, the Foundation is starting a specialist Diploma course in Aboriginal Mental Health. The Committee heard informally from Ms Marion Kickett that perhaps a Diploma in Women's Health could be considered in the future.

**Recommendation:**

State funding should be allocated to Marr Mooditj Foundation Inc. to establish a training course for Aboriginal antenatal educators.

**Recommendation:**

The State Government must allocate budgets from special Aboriginal projects to assist the Institute for Child Health Research to continue the Ngunytju Tjitji Pirni program based in Kalgoorlie.

**Recommendation:**

There must be State Government funding to research and test preconceptual, antenatal, childbirth, postnatal and early childhood education programs for Aboriginal women.

12.4 **ADOLESCENT WOMEN**

The Committee heard from Dr Jan Dickinson (26.4.95) -

they are a very high-risk group compared with the overall population because they have a greater incidence of preterm labour, pre-eclampsia, fetal growth restriction and anaemia. They often do not attend prenatal care and among them is a high incidence of drug abuse … if good prenatal care is applied to that group, their risk factor is comparable to that of the normal population.
12.4.1 Statistics

Women aged 19 years or less represented 6.0% of the total women confined.\textsuperscript{548} Over the 10 years, from 1984 to 1993, the percentage of teenage mothers has not changed very much and has fluctuated between 6.0% and 6.7%.\textsuperscript{549} Among Aboriginal mothers, 27.7% of births were to teenagers whereas 4.8% of births to Caucasian mothers were to teenagers.\textsuperscript{550}

12.4.2 Adolescent Clinic Model

There is an adolescent pregnancy clinic at King Edward Memorial Hospital for Women. The clinic looks after the pregnancy and labour of women who are 17 years and younger.

The Committee heard that the clinic has very good pregnancy outcomes. The caesarean section rate is 5% and since 1992, there have been no elective caesarean sections. All but one breech have been delivered vaginally. The number of epidurals used is less and major morbidity amongst infants is lower than the total hospital population.

The clinic offers "a very much one-to-one relationship and has a very good education program set at the adolescent level. The specialist obstetrician looks after all the girls in labour and she personally attends all the vaginal breeches. Dr Jan Dickinson (26.4.95) told the Committee -

having a specialist obstetrician for these girls is probably an expensive way of doing it. However it is worthwhile because we have such good outcomes. It indicates to me that because we really try to achieve a normal delivery for these girls, we can do it.

In the United States, three times as many adolescent girls have caesareans compared to Australia. Dr Dickinson also explained -

they look at them as a very high-risk caesarean section group. They think that a 12 year old girl cannot have a normal delivery. That is absolute nonsense. Most of our young girls are extremely stoic and labour beautifully.

The NHMRC \textit{Draft Report on Options for Effective Care in Childbirth} recommends -

special services within maternity units and elsewhere need to be provided for adolescent girls who are pregnant. These should include "drop-in" services with staff who are cognisant of the needs of this special group.\textsuperscript{551}

Dr Dickinson (26.4.95) told the Committee that although young women can have their babies easily -

obviously when they leave the hospital, things are not quite so rosy and there are major ongoing problems. It is very disappointing that very young girls continue to get pregnant. It indicates that our contraceptive policies are not working all that well.

\textsuperscript{548} Health Department of Western Australia. \textit{Perinatal Statistics in Western Australia}. 1993; p 7.

\textsuperscript{549} \textit{ibid}. p 55.

\textsuperscript{550} \textit{ibid}. p 7.

\textsuperscript{551} National Health and Medical Research Council. \textit{Draft report on options for effective care in childbirth}. 1994.
Often their partners find it hard to adjust to having a baby.

**Recommendation:**

The practice of obstetric care with emphasis on antenatal care, postnatal care and continuity of care should be available to all adolescent mothers.

### 12.5 OLDER WOMEN

#### 12.5.1 Statistics

Western Australian women are delaying childbirth. Over the ten years from 1984-1993, the percentage of women aged 35 years and over having babies has almost doubled. In 1993, 11.2% of all women who had babies were aged 35 years and more and 526 women (2.1% of all women confined) had their first confinement. This trend has been observed for Australia as a whole and overseas, and reasons for this include education, careers, modern contraception and financial considerations.

Many of the older women having their first babies have delayed pregnancy for many years and they regard their pregnancy as precious and they expect a perfect outcome. This attitude is also adopted by the families, attendants, midwives and doctors. These women may be well-educated, privately insured and used to being in control of their lives and hence they may want to be in control of their pregnancy. The Committee heard that if something goes wrong for these women, they may not cope well.

Women are encouraged to have a career before starting a family and consequently have fewer children later in life. They are correspondingly more concerned as to a perfect outcome, and they look to medical science to fulfil the expectation.

A recent study showed that women delivering their first child at 35 years of age and over were at increased risk of pre-existing hypertension, antepartum haemorrhage, preterm delivery and breech presentation. They are also more likely to have an operative delivery, induced labour and/or an epidural anaesthetic.
The Committee heard from Dr Anne Read (8.2.95) that -

a woman of 35 years and over ... faces 12 times the risk of a teenager of having an emergency
caesarean section with her first baby.

and

given that today more older women are pregnant and an increasing number of older mothers are
giving birth for the first time, our caesarean section rate is likely to continue to increase (and)
also the other operative deliveries. A risk factor such as maternal age may represent underlying
social, behavioural and attitudinal factors which are difficult to investigate in a quantitative way.
It may be that those factors are more important than any biological risk.

12.6 WOMEN WITH DISABILITIES

Women with physical disabilities e.g. sight and hearing impairment, who would benefit from
midwifery care in their own environment are unable to access the service because of the lack of
accurate and unbiased information given to them and the high cost of care in comparison to the
Medicare benefits.557

The Expert Maternity Group in the UK558 recommended that women with disabilities should have
full access to services and have the confidence that their needs are fully understood.

The Committee heard that in Western Australia, women should have access to midwifery care in
their own home without cost to themselves, if this would suit their psycho-social needs.559

12.7 WOMEN WITH A CHEMICAL DEPENDENCY

General practitioners and other health professionals in the community can help pregnant women
who have queries about alcohol and other drug use.

More specialised help is available at the Chemical Dependency Clinic located at KEMH's
Hensman Road Clinic. Women can be referred to the free and confidential service by a general
practitioner. The antenatal clinic is staffed by KEMH health professionals and the Western
Australian Alcohol and Drug Authority. The team of an obstetrician, nurse and social worker
offers -

! assessment of a woman's needs for herself, baby and family;
! support and care throughout her pregnancy and confinement;
! discharge planning with referral to appropriate support agencies; and
! counselling.

557 Submission 11 - Ms C Cook, et al.
559 Submission 11 - Ms C Cook, et al.
RECOMMENDATIONS

Recommendation:

Health professionals must be better informed about the specific needs of different cultural groups and know where to obtain relevant information.

Recommendation:

Women from different communities must be actively consulted about any particular cultural needs of their communities in relation to pregnancy and childbirth.

Recommendation:

Full consultation with the Aboriginal community (families, mothers, opinion leaders), obstetricians, GPs, midwives, and traditional carers, over a 6-12 month period, must take place before a cultural birthing centre could proceed.

Recommendation:

Health professionals offering maternity services for Aboriginal women and their families, and other hospital employees who come into contact with Aboriginal people must be given the opportunity to learn about Aboriginal culture.

Recommendation:

State funding should be allocated to Marr Mooditj Foundation Inc. to establish a training course for Aboriginal antenatal educators.
Recommendation:
The State Government must allocate budgets from special Aboriginal projects to assist the Institute for Child Health Research to continue the Ngunytju Tjitji Pirni program based in Kalgoorlie.

Recommendation:
There must be State Government funding to research and test preconceptual, antenatal, childbirth, postnatal and early childhood education programs for Aboriginal women.

Recommendation:
The practice of obstetric care with emphasis on antenatal care, postnatal care and continuity of care should be available to all adolescent mothers.
CHAPTER THIRTEEN

ECONOMICS OF CHILDBIRTH

13.1 INTRODUCTION

The Committee considered a number of economic issues during its investigations. These included the cost of obstetric deliveries in Western Australia, Medicare rebates, remuneration for health professionals and how funding for obstetrics could be better utilised.

13.2 OBSTETRIC COSTS

13.2.1 Delivery Costs

The Committee was interested to examine the costs of different interventions in Western Australia. In 1993-1994, the total costs for hospital deliveries was over $64 million (Table 33). The average DRG cost of all hospital deliveries was $2,573; caesarean sections cost about twice as much as vaginal deliveries (Table 33).

The Committee did a hypothetical calculation based upon the average DRG cost for all caesarean sections ($4,380.51) and the average DRG cost for all vaginal deliveries ($2,087.92) and found that if the caesarean section rate could be reduced from 21.2% (1993-94 figure) to 15.2%, the cost saving could be over $3.4 million (over 5% of the total cost for hospital deliveries). The area of realisable savings is worthy of further investigation.

Researchers in the United States estimated that if the target caesarean section rate of around 12% was achieved in 1991, there would have been an over $1.3 billion saving to the US health-care system.\(^{560}\)

13.2.2 Bed Day Costs

The Committee was interested to examine the possible cost saving to hospitals if more women decide to be part of an early discharge program after delivery. The bed day costs for tertiary hospitals and public non-teaching hospitals are $569 and $334 respectively.\(^{561}\) The Committee noted that there were 14,239 cases of "vaginal delivery without complicating diagnosis" who remained in hospital for an average of 4.4 days. If 50% of these women decided to opt for early discharge after two days, the saving could be over $5.7 million (based upon the $334 bed day cost). In addition, to the potential resource savings, there are the social benefits which might be gained by women by returning to their homes and communities. However, there must be postnatal domiciliary care services available in the community to care for these women. Once again the area of realisable savings should be investigated.

Quite obviously, there will also be a saving to the total health budget if more low-risk deliveries occur in non-teaching hospitals.


\(^{561}\) Data provided by the Health Department of Western Australia, 1995.
The Committee has looked at areas where there could be some cost savings. However, the Committee does not wish to see a reduction in the overall budget for obstetric services. Rather, if savings are possible, the money should be redistributed to provide antenatal, postnatal and community education programs, postnatal domiciliary care, and additional funding to supplement the Alternative Birthing Services Program.

Table 33: PREGNANCY AND CHILDBIRTH RELATED DRGs (MDC 14) 1993-1994

<table>
<thead>
<tr>
<th>Diagnostic Related Grouping</th>
<th>Cases</th>
<th>Bed Days</th>
<th>Average LOS*</th>
<th>Average Cost</th>
<th>Total Cost</th>
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<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Days</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>670 Caesarean delivery w/o complicating diagnosis</td>
<td>3138</td>
<td>21972</td>
<td>7</td>
<td>$4,032</td>
<td>$12,652,416</td>
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<tr>
<td>671 Caesarean delivery with moderate complicating diagnosis</td>
<td>753</td>
<td>6022</td>
<td>8</td>
<td>$4,238</td>
<td>$3,191,214</td>
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<tr>
<td>672 Caesarean delivery with severe complicating diagnosis</td>
<td>1378</td>
<td>14699</td>
<td>10.7</td>
<td>$5,252</td>
<td>$7,237,256</td>
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<tr>
<td>674 Vaginal delivery w/o complicating diagnosis</td>
<td>14239</td>
<td>63122</td>
<td>4.4</td>
<td>$1,926</td>
<td>$27,424,314</td>
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<td>675 Vaginal delivery with moderate complicating diagnoses</td>
<td>2550</td>
<td>13607</td>
<td>5.3</td>
<td>$2,270</td>
<td>$5,788,500</td>
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<tr>
<td>676 Vaginal delivery with severe complicating diagnosis</td>
<td>2635</td>
<td>16679</td>
<td>6.3</td>
<td>$2,704</td>
<td>$7,125,040</td>
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<tr>
<td>677 Vaginal delivery with O.R. procedure</td>
<td>206</td>
<td>1354</td>
<td>6.6</td>
<td>$3,146</td>
<td>$648,076</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>24,899</td>
<td>137,455</td>
<td>5.52</td>
<td><strong>$2,573</strong></td>
<td><strong>$64,066,816</strong></td>
</tr>
</tbody>
</table>

* Average length of stay.

SOURCE: Hospital Morbidity Data System, Health Statistics Branch, Health Department of Western Australia
Recommendation:

Money from the State health budget which might be saved if the caesarean section rate is reduced or if more women opt for early discharge from hospital must be utilised to provide education programs, postnatal domiciliary care programs and funding for the provision of alternative birthing services.

13.3 MEDICARE REBATES

Medicare will pay 75% of the scheduled fee for obstetric procedures performed by a medical practitioner but will pay nothing if treatment is given by a non-medical practitioner.

The Medicare Benefits for obstetric procedures are shown in Table 34.

Table 34: MEDICARE BENEFITS

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Procedure</th>
<th>Fee and Benefit</th>
</tr>
</thead>
</table>
| 16500   | ANTENATAL CARE (not including any service or services to which item 16517 applies) where the attendances do not exceed 10 - each attendance. | Fee: $24.45  
Benefit: 75% = $18.35  
85% = $20.80 |
| 16503   | ANTENATAL CARE (not including any service or services to which item 16517 applies) where attendances exceed 10. | Fee: $244.50  
Benefit: 75% = $183.40  
85% = $216.40 |
| 16507   | CONFINEMENT AND POSTNATAL CARE for 9 days where the medical practitioner has not given the antenatal care. | Fee: $293.70  
Benefit: 75% = $220.30  
85% = $265.60 |
| 16510 S | CONFINEMENT AS AN INDEPENDENT PROCEDURE BY A SPECIALIST in the practice of his or her speciality, where the patient is referred by another medical practitioner including all attendances related to the confinement. | Fee: $114.45  
Benefit: 75% = $85.85  
85% = $97.30 |
| 16513   | CONFINEMENT, incomplete, with or without postnatal care for 9 days where the patient is referred to a specialist in the practice of his or her speciality or the patient's care is transferred to another medical practitioner for completion of the delivery. | Fee: $114.45  
Benefit: 75% = $85.85  
85% = $97.30 |
| 16517   | ANTENATAL CARE, CONFINEMENT with delivery by any means (including caesarean section) AND POSTNATAL CARE for 9 days. | Fee: $629.45  
Benefit: 75% = $472.10  
85% = $601.35 |
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Procedure</th>
<th>Fee and Benefit</th>
</tr>
</thead>
</table>
| 16520  | CAESAREAN SECTION and postnatal care for 9 days where the patient has been referred to a specialist in the practice of his or her specialty or the patient's care has been transferred to another medical practitioner for management of the confinement and the practitioner who performs the caesarean section did not provide the antenatal care. | Fee: $449.90  
Benefit: 75% = $337.45  
85% = $421.80 |
| 16523  | TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones - each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance. | Fee: $15.95  
Benefit: 75% = $12.00  
85% = $13.60 |
| 16555  | ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) | Fee: $26.45  
Benefit: 75% = $19.85  
85% = $38.95 |
| 16567  | TREATMENT OF POST-PARTUM HAEMORRHAGE by special procedures such as packing of uterus as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances. | Fee: $124.95  
Benefit: 75% = $93.75  
85% = $106.25 |
| 16573  | THIRD DEGREE TEAR, repair of, involving anal sphincter muscles as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances. | Fee: $187.45  
Benefit: 75% = $140.60  
85% = $159.35 |


13.4 REMUNERATION FOR HEALTH PROFESSIONALS

In 1985, the NHMRC Working Party to Investigate Variations in Caesarean Section Rates in Australia concluded that fee-for-service remuneration might accelerate the rise in the rate of caesarean sections and recommended that a global fee be introduced irrespective of delivery. This came into effect in 1988, but has had no apparent impact upon the caesarean section rate. Dr James King suggested that -

a global fee might actually work as an inducement to intervene on the grounds that a caesarean section is often a much quicker option for a busy obstetrician than dealing with the uncertainties involved in the expectant management of natural labour and birth.


563 Submission 2 - Dr James King.
Dr King suggested that obstetricians should be rewarded for avoiding unnecessary intervention and a higher remuneration be offered for a normal delivery compared to an operative delivery. Dr Nick Bretland, a GP obstetrician felt "there were no financial incentives to encourage intervention".\textsuperscript{564} He outlined the various costs.

The Medicare benefit schedule fee of $625 covers delivery by any means including caesarean section. This fee has been set in a free marketplace where the AMA recommended fee is $1,600 and independent midwives charge $1,200 to $1,400 for each delivery. When one considers the fact that obstetric insurance premiums are $25,000pa [per annum] for specialists and $5,000pa for general practitioners, it becomes obvious that the major financial incentive is to abandon obstetrics altogether!

Dr Bretland felt that increasing obstetricians fees "will help stem the loss of those currently practising and more importantly it may encourage those in training to remain as practising obstetricians" and not to branch out into the more lucrative field of gynaecology.

13.4.1 Remuneration for GPs

Remuneration for GPs has been discussed previously in Chapter Seven.

Dr Katrina Alexander (9.2.95) told the Committee -

if the specialist just gives advice, it [the financial arrangement] is fine. If the specialist takes over, the GP fee is really low. The rebate for confinement with referral to a specialist where the specialist takes over is much less than a normal delivery.

Dr Alexander agreed that GP obstetricians "are not necessarily getting a great remuneration in relation to their costs in time and insurance". She felt the area should be looked at.

The Committee felt that remuneration for GP obstetricians is fairly low when the length of time involved and the cost of insurance are considered. The Committee would expect to see an improvement in this situation with the release of the Non-teaching Hospitals Agreement which is being negotiated currently in Western Australia.

13.4.2 Remuneration for Obstetricians as Consultants.

The Committee was interested to examine ways in which obstetricians can be rewarded for acting as consultants only, unless their skills are required for a procedure. The Committee hoped this would allow more general practitioners to do more low to moderate-risk deliveries.

If a specialist is called in to see a patient but does not take over management of a case, he/she receives remuneration from the Medicare Schedule for a "specialist, referred consultation - surgery, hospital or nursing home".\textsuperscript{565} This implies "professional attendance at consulting rooms, hospital or nursing home by a specialist in the practice of his or her own specialty where the patient is referred to him or her". The current remuneration is $61.75. Under the current Medicare Schedule, this fee applies to obstetricians and the Committee feels that this remuneration is very low. There is scope for a special Medicare item specifically for specialist

\textsuperscript{564} Submission 12 - Dr Nick Bretland.

obstetricians where they receive higher remuneration if they are called out to give expert advice. This would not apply if the patient was the specialist's own patient.

The Committee acknowledged the concerns of specialist obstetricians that as a result of increased insurance premiums they need to perform a certain number of deliveries in order to cover their costs. The Committee discussed the possibility of paying obstetricians more when they treat high-risk patients who require specialised treatment as a way to try to encourage them to leave the low-risk cases to GP obstetricians and midwives working together.

**Recommendation:**

Payments under the Medicare Benefits Schedule should be upgraded to give adequate remuneration to specialist consultants who provide a consultancy for general practitioners. Medicare should review the "global fee" for obstetrics taking into account the extra degree of skill required for a vaginal breech delivery and vaginal delivery of twins.

Remuneration for specialists is also discussed in Chapter Seven.

13.4.3 Remuneration for Midwives

The Committee heard from several witnesses about the problem of reimbursement of midwives fees.

Currently women who choose independent midwives are financially disadvantaged because of their choice. The re-imbursement of midwifery fees would allow many more women this choice which would reduce the incidence of intervention.566

The Committee heard that some "private medical insurance companies rebate less than 50% of the fee, calling it an "ex-gratia" payment"567 but there is no Medicare rebate.

Dr Woollard (8.2.95) told the Committee "we oppose it [Medicare rebates for midwives], not in an anti-midwife way, but simply because there are better things to do with Medicare money at this time".

The Committee felt that women who choose to be cared for by a community midwife during pregnancy and childbirth should be able to claim a Medicare rebate.

566 Submission 14 - Ms Theresa Clifford and Ms Bronwyn Key.

567 Submission 11 - Ms C Cook, et al.
Recommendation:

The Federal Government should provide Medicare rebates for women who choose to be cared for by a midwife in private practice.

13.5 SUGGESTED USE OF MATERNITY SERVICE FUNDING

The Committee also received many suggestions which addressed better use of maternity service funds. Some of these include -

- Funding allocated on giving/suturing of episiotomies by GPs and obstetricians should be removed. 568

- Money spent on intervention could be better utilised on programs to promote primary health care in pregnancy. 569

- Funds could be utilised in providing birth options for women who are healthy. 570

- Funding should be distributed where it will benefit the majority of people ... Options available to a few are not in accordance with equality therefore, should not be pursued. Resources should be channelled towards education of the community and health professionals alike. 571

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568 Submission 36 - Mr Bruce Coulson.
569 Submission 37 - Ms Kathleen Smedley and Ms Joanne Davies.
570 Submission 43 - Ms Janice Butt.
571 Submission 50 - Ms Anne-Marie Widermanski, et al.
RECOMMENDATIONS

Recommendation:

Money from the State health budget which might be saved if the caesarean section rate is reduced or if more women opt for early discharge from hospital must be utilised to provide education programs, postnatal domiciliary care programs and funding for the provision of alternative birthing services.

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**WITNESSES WHO APPEARED BEFORE THE COMMITTEE**

<table>
<thead>
<tr>
<th>Name of witness</th>
<th>Title</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ms Joan Greenwood</td>
<td>Midwifery Officer (Rtd) Department of Health, England</td>
<td>8.8.94</td>
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<tr>
<td>Dr Gareth John Goodier</td>
<td>Chief Executive Officer King Edward Memorial Hospital for Women</td>
<td>17.10.94</td>
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<tr>
<td>Professor Constantine Michael</td>
<td>Professor, Obstetrics and Gynaecology University of Western Australia</td>
<td>7.11.94</td>
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<tr>
<td>Dr Ian Lindsay Rouse</td>
<td>Director, Health Statistics Health Department of Western Australia</td>
<td>1.12.94</td>
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<tr>
<td>Dr Neil John Thomson</td>
<td>Director, Epidemiology Health Department of Western Australia</td>
<td>1.12.94</td>
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<tr>
<td>Mrs Vivien Gee</td>
<td>Coordinator Midwives’ Notification System Health Department of Western Australia</td>
<td>1.12.94</td>
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<tr>
<td>Dr Sandra Marie Webb</td>
<td>Coordinator, Reproductive Technology Health Department of Western Australia</td>
<td>1.12.94</td>
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<tr>
<td>Dr Allan Quigley</td>
<td>Medical Consultant Health Department of Western Australia</td>
<td>1.12.94</td>
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<tr>
<td>Dr Michael James Paech</td>
<td>Head, Department of Anaesthesia King Edward Memorial Hospital for Women</td>
<td>8.2.95</td>
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<tr>
<td>Professor Fiona Juliet Stanley</td>
<td>Director Institute for Child Health Research and Professor, Department of Paediatrics University of Western Australia</td>
<td>8.2.95</td>
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<tr>
<td>Dr Anne Winifred Read</td>
<td>Epidemiologist &amp; Senior Research Officer Institute for Child Health Research</td>
<td>8.2.95</td>
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<tr>
<td>Dr Barry Sam Fatovich</td>
<td>State Director Royal Australian College of General Practitioners Training Program</td>
<td>8.2.95</td>
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<tr>
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<td>Ms Sherryl Pope</td>
<td>Senior Clinical Psychologist</td>
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<td>Professor John Phillipps Newnham</td>
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<td>King Edward Memorial Hospital for Women</td>
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<tr>
<td>Dr Keith Victor Woollard</td>
<td>President</td>
<td>9.2.95</td>
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<tr>
<td>Dr Katrina Alexander</td>
<td>GP Obstetrician and Chairman, Australian Medical Association (WA Branch),</td>
<td>9.2.95</td>
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<tr>
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<td>Women's Health Issues Committee</td>
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<tr>
<td>Dr Donald Rowland Bott</td>
<td>GP Obstetrician</td>
<td>9.2.95</td>
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<td>Dr Graham Edward Smith</td>
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<td>Dr Dale Vincent Evans</td>
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<td>9.2.95</td>
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<tr>
<td>Ms Jennifer Leanne Wood</td>
<td>Registered Midwife</td>
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<td>Dr Nicholas Peter Bretland</td>
<td>GP Obstetrician</td>
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<td>Dr Donald Melrose Clark</td>
<td>Obstetrician and Gynaecologist</td>
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<td>Dr Hamish Edgar McGlashan</td>
<td>Obstetrician and Gynaecologist</td>
<td>16.2.95</td>
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<tr>
<td>Dr Myra Brown</td>
<td>GP Obstetrician and spokesperson</td>
<td>16.2.95</td>
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<tr>
<td></td>
<td>for obstetrics, WA Faculty of the Royal Australian College of General</td>
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<td>Ms Enid Facer</td>
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<td>Ms Catherine Anne Cook</td>
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<td>Assoc Prof Robin Jennifer Watts</td>
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<td>Ms Yvonne Louise Hauck</td>
<td>Lecturer, School of Nursing Edith Cowan University</td>
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<td>Ms Janice Butt</td>
<td>Coordinator, Midwifery Course King Edward Memorial Hospital for Women</td>
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<td>Mrs Barbara Joan Horner</td>
<td>Principal Education Officer Nurses' Board of WA</td>
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<td>Dr Harry Cohen</td>
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<td>Ms Caroline Flint</td>
<td>Practising Independent Midwife and President, Royal College of Midwives United Kingdom</td>
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<td>Ms Magretta Wallis</td>
<td>Clinical Nurse Specialist, Maternity Swan Health Service</td>
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<td>Dr Colin Hughes</td>
<td>General Practitioner</td>
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<td>Ms Patricia Anne Tibbett</td>
<td>Director of Nursing Swan Health Service</td>
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<td>Mr Peter Mott</td>
<td>General Manager Swan Health Service</td>
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<td>Dr Diana Elizabeth Wellby</td>
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<td>Dr Brian Williams</td>
<td>Director WA Centre for Remote and Rural Medicine</td>
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<td>Dr Leslie L Reti</td>
<td>Chairman, Royal Australian College of Obstetricians and Gynaecologists Quality Assurance Committee</td>
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<td>Dr Jan Elizabeth Dickinson</td>
<td>Obstetrician and Gynaecologist</td>
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<tr>
<td>Dr Ken Mark McKenna</td>
<td>Senior Lecturer, Obstetrics and Gynaecology and Assoc. Dean, Teaching and Learning, Faculty of Medicine University of Western Australia</td>
<td>26.4.95</td>
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<td>Ms Bronwyn Key</td>
<td>Midwife Coordinator Fremantle Community Midwives Information Centre</td>
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<td>Ms Rosemary Halton</td>
<td>Vice President Birth Place Support Group Inc.</td>
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<td>Ms Sandra Hudson</td>
<td>President Birth Place Support Group Inc.</td>
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<td>Dr Peter Richardson</td>
<td>Chairman, National Association of Specialist Obstetricians and Gynaecologists</td>
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<td>Mr Peter Michael Forbes</td>
<td>Executive Officer, Medical Defence Association of WA and Chief Executive Officer Medical Defence Union of Australia</td>
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<td>Mr Dominic John Bourke</td>
<td>Solicitor, Clayton Utz</td>
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<td>Mr Nigel Fergus McBride</td>
<td>Director, Legal Administration Health Department of Western Australia</td>
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<td>Mrs Jacqueline Robinson</td>
<td>Consumer's Representative</td>
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<td>Mrs Henny J Ligtermoet</td>
<td>Antenatal Teacher (Rtd)</td>
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<td>Ms Carolyn Mary Thorogood</td>
<td>President, Australian College of Midwives Inc. (WA) and Lecturer, School of Nursing Curtin University of Technology</td>
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<td>Mrs Vivien Gee</td>
<td>Vice President, Australian College of Midwives Inc. (WA) and Coordinator, Midwives Notification System, Health Department of Western Australia</td>
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<td>Dr Corrado Minutillo</td>
<td>Neonatal Paediatrician</td>
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<td>Dr Ian Lindsay Rouse</td>
<td>Director, Health Statistics Health Department of Western Australia</td>
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<td>Mrs Vivien Gee</td>
<td>Coordinator, Midwives Notification System Health Department of Western Australia</td>
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SUBMISSIONS RECEIVED BY THE COMMITTEE

1. Mr John White.
2. Dr James King, Clinical Associate Professor, Mater Misericordiae Mothers Hospital.
3. Dr Mark McKenna, Senior Lecturer, Department of Obstetrics and Gynaecology, King Edward Memorial Hospital for Women.
5. Dr Michael Paech, Head, Department of Anaesthesia, King Edward Memorial Hospital for Women.
6. Mrs JL Wright, Midwife.
7. Dr Anne Read, Senior Research Officer, Institute for Child Health Research.
8. Ms Rose Halton, Vice President, Birthplace Support Group Inc.
9. Dr Donald Melrose Clark, Obstetrician and Gynaecologist, St Anne's Medical Centre, St Anne's Mercy Hospital.
10. Dr Ralph S Hickling, Gynaecologist and Sonologist.
12. Dr Nick Bretland, GP obstetrician.
13. Mr I V Lishman, General surgeon.
14. Ms Theresa Clifford and Ms Bronwyn Key, Fremantle Community Midwives.
15. Ms Linda Rawlings.
16. Dr Richard Christie and Dr David Roberts.
17. Dr SN Campbell and Dr PA Richardson, Paediatricians.
18. Dr Colin Hughes, Coordinator, Swan Hills Division of General Practitioners Ltd.
19. Ms Janet Timmins, Professional Projects Officer, Nurses' Board of Western Australia.
20. Mrs Margo Campbell.
21. Ms Aileen Fortescue, Director of Nursing, Denmark District Hospital.
22. Dr Hamish McGlashan, Obstetrician and Gynaecologist.
23. Ms Helen Laing, Registered Midwife.
24. Dr Donna Mak, Medical Practitioner.
25. Dr Jane Fisher, Postdoctoral Research Fellow, Key Centre for Women's Health in Society, University of Melbourne.
26. Mrs Barbara Kelly, State President, The Country Women's Association of Western Australia (Inc.).
27. Dr Panos Maouris, Obstetrician and Gynaecologist.
28. Dr K Howe, GP Obstetrician.
29. Dr MJ Davies, President, Australian and New Zealand College of Anaesthetists.
30. Mrs Henny Ligtermoet, Antenatal Teacher.
31. Ms Shirley Breese and Dr Karen Lane, The Maternity Coalition (Inc.).
32. Ms Denise Hynd, Midwife.
33. Anna Bosco, Michel Burgum, Hilary Cross, Rosemary Keenan, Angelica Orb and Jennifer Wood, School of Nursing, Curtin University of Technology.
34. Dr Peter Maguire, GP Obstetrician.
35. Dr Mary Surveyor, Medical Director, Osborne Division of General Practice Ltd.
36. Mr Bruce Coulson, Midwife.
37. Ms Kathleen Smedley and Ms Joanne Davies, Midwives, Kalgoorlie Regional Hospital.
38. Ms Dianne Tomlinson, Practising midwife.
39. Dr D Hayward, Chairman and Dr RJ Boulter, Immediate Past Chairman, Australian Society of Anaesthetists (WA).
40. Ms Athalie Johnston and Ms Mary Della-Vedova.
41. Ms Sue Terry, Director of Nursing and Midwifery Services, King Edward Memorial Hospital for Women.
42. Mrs Barbara Horner, Principal Education Officer, Nurses' Board of Western Australia.
43. Mrs Janice Butt, Coordinator, Midwifery Course, King Edward Memorial Hospital for Women.
44. Peel Health Service.
45. Ms Ann Saul and Ms Dell Horey, Homebirth Australia Inc.
46. Mrs Sharon Gae Taylor.
47. Mrs Doreen McCarthy, Director of Nursing, Royal Perth Hospital.
48. Ms Jane Muir, President, Women's Advisory Council of Western Australia.
49. Mr Peter Mott, General Manager, Swan Health Service.
50. Ms Anne-Marie Widermanski, Ms Pamela Robinson, Ms Lyn McArthur, Ms Joy Wilcock and Ms Christine Walsh, Glengarry Hospital.
51. Ms Dell Horey, Maternity Alliance Inc.
52. Ms Noaleen Crosbie.
53. Dr John Stevenson.
54. Dr Tim Pavy, Staff Specialist Anaesthetist, Department of Anaesthesis, King Edward Memorial Hospital for Women.
55. Dr Harry Cohen, Head of Department of Gynaecology, King Edward Memorial Hospital for Women.
56. Ms Jacqui Robinson, Ms Liz Burrell, Ms Maxine Drake, Health Consumer's Council of WA (Inc.)
57. Dr Graham Smith, Chairman, WA Royal Australian College of Obstetricians and Gynaecologists.
58. Dr Robina Silva, Obstetrician and Gynaecologist.
59. Mr Wayne Smith.
60. Mr Derk Brocx, Clinical Hypnotherapist.
61. Ms Judith Bowling.
63. Dr Norman Gage, Obstetrician and Gynaecologist.
64. Ms Rose Halton, Vice President, Birthplace Support Group Inc.
65. Dr Marsden Wagner.
66. Mr Patrick O'Donaghue, Midwife.
67. Dr Bev Thiele, Senior Lecturer, Women's Studies, School of Social Studies, Murdoch University.
68. Ms Roslyn Hurst and Dr Anne Stephens, Bega Garnbirringu Health Service.
69. Ms Carol Thorogood, President Australian College of Midwives Inc. (WA).
70. Mrs Vivien Gee, Coordinator, Midwives' Notification System.
71. Anonymous submission.
72. Anonymous submission.
73. Anonymous submission.
74. Mr Peter Jennings, Australian Medical Association (WA).
75. Dr Sandra Eades, Perth Aboriginal Medical Service.
76. Dr Keith Woollard, President of the Australian Medical Association of WA.
77. Ms Margaret Baird, Manager, Mandurah Birth Centre.
78. Ms Sylvia Miles, Midwife, Collie District Hospital.
79. Ms Kate Cook, Community Midwife.
80. Ms Jacqui Robinson.
81. Ms Robyn Collins, Midwifery Clinical Manager Family Birth Centre.
APPENDICES
The following reports include information that was discussed with the Committee during its investigative tours. Since the Committee's visits the situations may have changed at some of the hospitals, e.g. the opening of birth centres.

FAMILY BIRTH CENTRE, KING EDWARD MEMORIAL HOSPITAL FOR WOMEN

The Committee visited the Family Birth Centre (FBC) on 7 November 1994. Following a tour of the Centre, the Committee met the Director of Nursing, Coordinator of Clinical Nursing and Family Birth Centre Midwives.

The FBC is not self-referring. All clients are seen by a GP first. Prior to June 1994, patients were referred direct to the centre by a GP. Women heard about the centre by word of mouth. Since June 1994, all referrals have been sent to the Hensman Road Clinic. There is a selection procedure and suitable clients are sent a letter inviting them to visit the FBC before they decide where they wish to have their baby. Women considered to be "high-risk cases" are not invited.

The medical selection criteria are in the process of being updated as a result of experience at the centre. A copy of the criteria is in Appendix E. The Committee heard that changes will include:

- the option of a FBC delivery for a woman who has previously had a caesarean section, followed by a vaginal delivery;
- alterations to the weight criteria.

Antenatal Assessment and Education

The initial booking visit lasts for 45 minutes which includes a physical assessment. Clients do not see a doctor unless this is thought to be necessary. A doctor will review the client's charts. Clients attend an early pregnancy discussion which is the same for both mainstream and FBC clients. Once a month there are discussion groups for clients. KEMH staff cover birth and baby care with some practical demonstrations. For a first baby, clients are encouraged to attend a six week antenatal course with a physiotherapist.

The education programs are not compulsory. However, it was generally felt that those who do not attend may have the greatest need. The discussion group for adolescents is held at 1pm, immediately prior to their antenatal visit. Adolescent mothers are encouraged to come back to the group six weeks after delivery to show their babies and to discuss the reality of the situation with their peers.

KEMH staff dovetail their education programs with child health nurses

Cancellations

Clients may cancel their booking with the FBC themselves. Those who cancel opt for either a homebirth or mainstream delivery. There does not appear to any indication of one group
cancelling more than others, e.g. first deliveries.

**Delivery**

There are four delivery rooms at the FBC and a bathroom. Women can labour in the bath but they do not give birth there. Everything required for the delivery is kept in the room and the delivery procedure is antiseptic rather than sterile. The midwives do not do routine suction unless the baby has inhaled meconium. There is a direct line to the special nursery but the baby does not leave its mother's room unless it is necessary. The midwives try to get a paediatrician to check the baby. Most mothers do not use the cots provided and have the baby in bed with them.

Mothers remain at the FBC for up to 24 hours after giving birth (average time 17 hours). They are followed up at home by domiciliary midwives. Mothers from the country are asked to stay in the metropolitan area (40 km radius) for up to seven days. This exclusion clause may be changed to try to get low-risk midwifery back into the community. In a mainstream hospital clients remain for up to 72 hours after a normal delivery and 120 hours after a caesarean section. There is a trend to reduce the number of hours spent in hospital.

**Intervention**

Midwives will induce a client if she has been four centimetres dilated for several hours by rupturing the membranes. Ergometrine is given to prevent post-partum bleeding.

**Need for Extended Services**

The demand for the FBC is increasing. The centre carries out 85 deliveries per month. The staff feel there is a need for another centre rather than an extension of the current site. There needs to be medical support near any FBC. A concern was expressed about clients having to leave their own area to attend a central location. The KEMH service is free in the public health system while other options are available in the private system.

**COLLIE DISTRICT HOSPITAL**

The Committee visited Collie District Hospital on Wednesday 22 February 1995. Following a tour of the hospital the Committee met with the hospital's Director of Nursing, midwives, community nursing staff and local GP obstetricians.

There is no specialist obstetrician in Collie but there are four GP obstetricians and three others who deliver occasionally. Two of the doctors perform caesarean sections. The doctors and midwives work together.

There are about 150 deliveries in Collie per year.

**Transfer**

Only a small number of women (estimated to be 10 per year) are transferred out of the area. The hospital policy is "baby in utero" goes to King Edward Memorial Hospital for Women and "baby born" goes to Princess Margaret Hospital. The reasons for transfer to Bunbury would be if some women preferred shared care or if they wished to see a specialist obstetrician.

Collie doctors would not refer patients to a specialist unless there is an emergency.
Reasons for transfer to Perth are -

- severe illness in the mother;
- pre-term - before 36 weeks.

**Collie Hospital**

The doctors in Collie are usually able to meet patients' requirements. If a woman is 36 weeks pregnant and six to eight centimetres dilated, the baby can be delivered in Collie.

Collie Hospital has more facilities than many other country hospitals. Doctors can do caesarean sections, epidurals and anaesthesia, and initial resuscitation.

Some women do want a "natural" delivery. During antenatal classes women are told what is available for pain relief and they make a choice at the time or staff will help women have as natural a labour as possible.

The hospital has records of deliveries from 1981 to the present time.

**Reasons for Intervention**

There are many factors leading towards intervention - fetal distress and being disadvantaged by a freely available epidural service.

One doctor felt that the balance of power is in the favour of the patient. They can demand ultrasound scans, epidurals and inductions.

Another doctor believed that there is a significant amount of intervention which leads to excellent outcome results. The prime aim for women is a good outcome.

**Inductions**

In Collie, the induction rate using Prostin is 26%.

**Epidural Analgesia**

In Collie about 15% of patients have epidural analgesia (EA) (this includes some caudal statistics).

The Committee heard that if the patient needs an epidural, they would probably have had an intervention anyway and if they don't need an epidural they would probably have a normal labour. Epidurals are only given when they are absolutely necessary.

The decision to give an epidural must come from the staff looking after the patient, or the patient. If an epidural service is available as it is in Collie, it will be called upon.

The Collie staff felt they had never seen a woman have an epidural who did not want one.

The more educated the patient, the less likely they were to have an EA because they know of potential complications and have higher expectations.

**Electronic Fetal Monitoring/Cardiotocography (CTG)**
The hospital has an antenatal CTG for antenatal assessment. They use ultrasound and CTG to monitor fetal well being. The hospital does not have a machine for intrapartum fetal monitoring. They do not have the backup facility to measure fetal scalp pH. They believe CTG creates false fetal distress syndrome and therefore increases the rate of caesarean section.

The Committee heard from one doctor that he has done very few caesarean sections for fetal distress - about five in 11 years.

**Training of GPs**

The Committee heard that training of GP obstetricians is not adequate. Doctors are not told about the differences between the city and country, e.g. that specialists and backup are available in the city while there is no backup in the country and doctors may have to handle all the problems.

GPs learn to do normal and assisted deliveries and are not taught to do caesarean sections. The expectation of doctors is they will treat the abnormal. If doctors do not have the appropriate training, there are problems because they cannot deal with difficult cases.

**Midwife Training**

Collie has experienced midwives who do a capable job. They have to be multi-skilled. In order to be cost-effective, midwives also care for general patients. The Committee was told that midwifery training is not adequate to prepare midwives for coming to Collie.

There was concern about the aging population of midwives in Collie. There are currently 15 trained midwives all between 30 and 40 years of age. There is a reluctance to come to the country and there is deskilling of midwives and GPs. Young midwives coming to the hospital would learn quickly.

**Postnatal Care**

There is a problem with a decline in breastfeeding rates. There is one qualified counsellor in Collie.

**Postnatal Depression**

Staff felt a lot of women did not realise they have postnatal depression but they are starting to become more aware of it.

**Aboriginal Women**

Aboriginal mothers are generally a poor group in the community. They are reluctant to attend antenatal classes. The nurses reported that one couple has attended in four years. Staff are investigating and liaising with Aboriginal health workers about antenatal classes.

Aboriginal babies are followed up after six weeks. They do not have a high readmission rate.

**Homebirths**

The Committee heard that a few years ago one midwife did 12 homebirths in two years. No nurses have applied to be accredited as independent midwives at the hospital.
It is difficult to do homebirths in the country. Midwives do not earn enough to support themselves. The distances travelled consume a lot of the fees. There is no backup service and it might take a long time to get help.

One of the doctors told the Committee that he has supported the homebirth midwives and is happy to share care. He has no problem with midwives managing antenatal care and delivery, but for a lot of doctors in country towns, if half of the deliveries go to midwives, the doctors are not financially able to stay.

**Place of Delivery**

The Committee heard that there is no reason why women have to go to the labour ward. Women do not have to focus on the labour ward, they can choose to stay in their own room. There are three single and two double rooms at the hospital and the chances of doubling up are slim.

If a labour ward is made to look more normal it provides women with choice. People have different wishes so there is a need to cater for a range of choices. A more homely environment is important for a good obstetric outcome, as it often reduces fear.

**Rural Practice**

Doctors are very reluctant to come to the country. However, two of the doctors present at the meeting had never practised in the city.

The Committee heard that it is hard to run a family practice without doing obstetrics.

**Continuity of Care**

The Committee heard that midwives doing obstetrics and antenatal care is sometimes raised as an alternative to a specialist. However, GPs see women prior to pregnancy and can offer a totality of care.

The midwives feel if a woman is comfortable with one midwife, they should be allowed to continue.

**Neonatal Transfers**

Babies may be transferred out of the hospital because of a lack of staff. There is only one midwife rostered on a given shift. However, others are brought in if there is a heavy workload. This leads to a problem because there will be a lack of staff for other shifts.

One doctor questioned the economics of flying a patient to Perth, rather than funding more staff. Patients get distressed when they are transferred.

**BUNBURY**

The Committee visited Bunbury on 23 - 24 February 1995. During the visit Members met with health professionals, including staff at Bunbury Regional Hospital, local medical practitioners; community groups and members of the public.

**Education**
The Committee heard of the need for more education in a number of areas. The need for general community education and the need to change people's attitudes was raised. Preconceptual clinics could help deal with dysfunctional relationships. Women need to be informed about the role of midwives as primary caregivers. Only a few women will attend postnatal classes. There is also a need for more school education. The Committee was told that the South West Homebirth Support Group gives talks to Year 12 students. The group raised the issue about what is an appropriate age to start educating school children about birth options. Antenatal education could occur in doctors surgeries. It was suggested that the Health Department of Western Australia could provide information about natural childbirth. It was also suggested that there should be education for partners of pregnant women to discuss how the women are coping.

At a public meeting, the Committee heard about a proposal for Alternative Birthing Services Program funding from a community midwifery scheme (the application has since been withdrawn). There are currently no community midwives accredited in Bunbury.

**Postnatal Depression**

The Committee heard that postnatal depression is underdiagnosed. It was felt that it would be important to look at communication issues. Women should be allowed to express what they want to a carer. Many women want a good experience, both emotionally and physically. The Committee heard that the sooner a mother and family are contacted postnatally the better, in order that they can talk about their experience.

The Committee was told that Aboriginal women have a high rate of postnatal depression

**Support in Pregnancy**

The Committee heard that doctors are not able to provide detailed one-to-one care and help with breathing, while midwives do so much. It is important to get to know a support person early in pregnancy who will follow the pregnancy all the way.

**Early Discharge**

A member of the community told the Committee she would like to see early discharge from hospital with midwives to support the woman at home. The Committee also heard there must be no gap with this program. There is no distinction made between women who leave early and those who stay in hospital for 5-6 days. Distance can make it hard to visit women in outlying areas.

**Role of the Midwife**

A midwife at the public meeting told the Committee that there needs to be a transition phase to move from being a hospital midwife to community midwifery. The Committee also heard that midwives have the experience and right to be at the birth, perform the delivery without the doctor and call them if necessary.
Bunbury Regional Hospital

A high proportion of obstetric problems come to Bunbury Regional Hospital so they influence the intervention rates at the hospital. In 1993, the caesarean section rate was 22.9%, forceps (9.97%), vacuum extraction (5.83%) and epidural and spinal anaesthesia (27.73%). Other forms of pain management are available and having a midwife with women during labour is a significant part of pain relief.

Continuity of Care

The Committee heard that patients build up a rapport with a midwife and are saddened when she goes off duty. It is hard to overcome this problem. However, the next day the patient is happy to have two midwives they know well. There was discussion of birth plans to ensure that when midwives change they can find out what a patient wants. There was concern that a birth plan can lock a woman into a certain delivery.

The Committee heard from members of the community that they would like more continuity of care.

Incentives for Community Midwives

The incentives could include orientation in training and financial reward. There was also discussion about midwife fees and rebates.

South West Homebirth Support Group

The group started in 1980 and offers support, publicises the option of homebirth and acts as a reference point for women choosing homebirth. The group raised the issue of the importance of debriefing and having a companion in labour. They felt there was a lower incidence of postnatal depression after a homebirth. The Committee heard that litigation works against women having a homebirth because it is hard to find a doctor willing to be present.

The Committee heard that midwives should be able to offer antenatal visits and shared care with GPs.

Midwifery Training

The Bunbury Regional Hospital supports registration training and practical experience. They have Curtin midwifery residents, but accommodation is a problem. The hospital also provides a two week refresher course for outlying hospitals. Concern was expressed over the potential shortage of midwives when KEMH closes.

Aboriginal Women

Many of the women are young and single and there are barriers to them attending antenatal classes. There also needs to be funding to run appropriate programs.

Young Women

Approximately 10% to 15% of pregnancies in the area are teenage pregnancies. It is necessary to access these young women to look at what they should be offered in hospital.

The Committee heard that young girls are not attending antenatal classes. It also heard that a
survey revealed that teenagers under 18 years-of-age wanted age specific services, a one-stop shop and an open and free service.

**Intervention**

The Committee met with a number of Bunbury doctors. There are a number of GP obstetricians and two specialist obstetricians in Bunbury. A number of issues were raised. These included the factors governing increased intervention such as consumer demand and medico-legal issues. It was felt that more midwifery involvement in antenatal and postnatal care was good and could help to reduce intervention rates.

One of the doctors felt that electronic fetal monitoring has a place but it should not be used for low-risk patients. He would wish to have a monitor to enable more vaginal births after caesarean section.

**Isolation**

The isolation of doctors in smaller centres leads to unique problems and stress where the doctor has to decide at an early stage whether to deliver without backup or transfer a woman to a larger centre.

**Peer Review**

A division of obstetrics and gynaecology is being established in the area which will provide the first step to peer review.

**Training and Recruitment of Doctors**

The Committee heard that young doctors should be sent to the country to get experience. There was also discussion about a survey conducted by one of the doctors which showed that very few general surgeons have obstetric training and perhaps all general surgeons should rotate through an obstetric hospital. It was also stated that people who go to rural centre for training are better off.

**Remuneration**

The doctors felt that obstetrics is badly remunerated. It was discussed that there could be cost savings if GPs offer medical support while obstetricians do specialised work.

There was also discussion about the new Bunbury Hospital. One of the doctors was keen to see all the rooms looking like low-risk areas but with easy access to equipment.

**PINJARRA**

The Committee visited Pinjarra (Murray) District Hospital on 24 February 1995 and met with health professionals from both Pinjarra and Mandurah.

**Mandurah**

The Mandurah hospital was built eight years ago because of the population increase. The two obstetric beds have never been used because there were no postnatal beds space. There has been a sense of limitation amongst the medical population about not using the unit.
A Mandurah Health Campus is planned for three years down the track in the short term. The Peel Health Services got a Federal grant to open the Mandurah Birthing Suite to give women a choice of place of delivery. The unit will be structured for low-risk women.

GPs have a grant to run a public antenatal clinic once a week with midwives which will have the full backup of specialist colleagues who are behind them to date, with this venture.

The unit will have two delivery beds. It will be short stay with an early discharge program. Women will be screened obstetrically and socially (to ensure they have backup). Women will be able to go home within 12 hours. Midwives are researching to see what the backup will be. Currently, there are only two GP obstetricians in Mandurah (there were nine last year). The reasons for the decline in members in the last two years are the unsocial on-call hours, fees are not outstanding, and the huge indemnity fees. A GP obstetrician needs to do 25 to 30 deliveries to break even.

**Pinjarra**

There are three GP obstetricians in Pinjarra. They have noticed an increase in workload, especially from Mandurah and the surrounding areas with the decline in Mandurah GPs. They service those from Mandurah, and from Yarloop to Serpentine. Historically, Pinjarra (Murray) District Hospital has been the centre of the service.

**Problems**

A problem is that in the whole region there is a discrepancy between the population base and the geographical distribution of services.

The problems in the near future include -

- increasing workload;
- ongoing fee problem;
- remuneration compared with indemnity fees;
- expectations placed by patients upon doctors;
- pressure placed on doctors as a result of expectations;

Long term problems include -

- changes in the Murray Shire and an increase in population. Therefore, there will be a need to maintain a birthing suite in Pinjarra;
- difficulty attracting GP obstetricians.

**Number of Deliveries**

In 1993, there were 443 deliveries at Pinjarra (Murray) District Hospital. In 1994, there were 457 and there were 41 in January 1995. The increase in births occurred in about 1992. The breakdown of births was approximately Mandurah (2/3) versus Pinjarra (1/3).

In 1994, of the 457 babies born at the hospital, about 257 were from Mandurah and 200 were from Pinjarra.

A substantial number of women will go to Rockingham or Perth under a specialist because they have problems or choose this as an option. Of the 580 babies born to Mandurah parents in 1994, 50% were delivered in Rockingham or Perth. Setting up the birthing suite in Mandurah will not
stop the number of babies being delivered outside the area.

There is a private family hospital in Rockingham that takes some patients away. The specialist obstetrician covers Pinjarra, Mandurah and Rockingham. There are two GP obstetricians and one specialist obstetrician living in Mandurah.

Statistics

The caesarean section rate was 16%. The epidural rate was nine per cent which is lower than usual, perhaps because they are not so readily available. Only one GP in Pinjarra can do epidurals regularly in close proximity.

Previously a lot of complicated cases went to Rockingham, but now there is a specialist working in the area if a woman needs a caesarean she will stay to have her baby. None of the GPs do caesarean sections. General surgeons will perform them occasionally.

Consumer demand for epidurals is increasing. More women in labour will request them earlier or without being prompted. Antenatal classes are increasing women's awareness. Patients also attending a obstetrician are being informed about epidurals at an earlier time.

However, the issue was raised that there is not much point in learning about epidurals in antenatal classes, if they are not available. One of the aims of the Alternative Birthing Services Program is to have antenatal education needs integrated with the service available, i.e. an integrated team of midwives talking to patients about the same things. Epidurals will not be available in Mandurah.

Women attending the Mandurah Birth Centre will have appropriate antenatal education from the same staff and will be delivered by someone they know and feel comfortable with. Hopefully this will reduce the need for epidurals as well as not raising their expectations.

The entry criteria for the birthing suite has yet to be decided.

Funding for Birthing Suite

They have got the funding. They want some midwives' positions to be part-time so there will be more staff available. There will be four FTEs (of which some will be shared positions), plus one coordinator and one Aboriginal health worker.

The number of women going through the suite will depend upon the entry criteria. At the moment, there are about 400 women from Mandurah being delivered a year. Based on obstetric and social criteria it is unlikely that more than 25% of the women will be eligible for the birthing suite, but it may increase to 50%. They hope for 100 to 120 women per year.

It is called an alternative birthing centre because it is funded under the Alternative Birthing Service Grant. There are various criteria under which one can set up a centre. They have gone for a shared care model - basically a GP and midwife shared care model. The difference with Mandurah is that there are no postnatal beds, so the mothers on the program will need to want to go home quickly (discharge 6 - 12 hours after delivery). They will be delivered in the unit. If it is 8.00 a.m., they will go home by 5.00 p.m., if its 11.00 a.m., it will be the following morning. The midwife team will be small. Therefore, the midwife who delivers them is likely to be the one who takes them home and they are likely to have met the other midwives who visit her over the nine day postnatal period and may have conducted her antenatal care in association with her GP and her antenatal education. There will be midwife/GP delivery at the centre.
Incentives for GPs

It was felt that once the hospital is built, things will improve. Most GPs are hospital trained and are naturally concerned that there are no beds. The reason they are setting up the birth centre is because doctors are dropping out of obstetrics. It will be three to four years before there are beds at the Mandurah Health Campus. Doctors felt if they did not push this issue now they would also give up obstetrics which would lead to the situation of having no GP obstetricians in Mandurah at all.

The Committee heard there was a concern that the Mandurah women (high-risk) who are not eligible for the birthing suite will be stretch Pinjarra’s resources and that the birthing suite will have removed the services of doctors from Mandurah.

There will be a change in the balance of services again when a full service is available in Mandurah.

There was discussion about whether patients from Pinjarra would be eligible to attend the Mandurah Birth Centre. It was suggested that if Pinjarra doctors had to provide a service to the birthing suite too, it would lead to a restriction of resources. It would also place an overburden on community midwives.

Role of Midwives

The view was expressed that midwives do not get treated as professionals. They should be because they have to take responsibility. They need recognition from the Health Department that they are practitioners in their own right. Allied health staff are treated better. They acknowledge that they require backup and they should be allowed to do their job.

Training

The Committee heard that midwives go on updating courses paid for by the Health Department while there is no facility or funding for GP obstetricians to continue training.

Remuneration

One doctor told the Committee that they are private practitioners but their fees are set by the Health Department of WA. Therefore, doctors are not in a position to charge private fees. Most of them see public patients in the State Health system. Perhaps there could be some incentive for GPs to stay in obstetrics if the terms and conditions of service were different.

Early Discharge Scheme

There is already an early discharge scheme in Pinjarra and Mandurah. Women go home when they are fit and ready. It works extremely well.

Women have a choice if they want to stay for a long time. It is up to them, their family and their doctor. For those who think the Birth Centre idea is more suitable for them and then they decide to stay longer, they are transferred across from Mandurah because there is no postnatal accommodation available for them at the moment.

There is an increase in the number of babies who have been early discharges from Perth who come back to Pinjarra to be cared for. The Committee heard that staff at Pinjarra are not always notified when a woman who has delivered in Perth and is discharged on the Early Discharge
Scheme is returning to Pinjarra.

Midwife Numbers

The Committee was told that it is difficult to attract midwives to the area. There is a big turnover in midwife numbers.

Some midwives are looking for something different from the traditional birthing suite and some of the midwives currently working at Pinjarra will want to apply for the positions in Mandurah.

There are no incentives for qualified midwives to return to work to be reregistered after having a family. They have to do considerable retraining at their own expense to be reregistered. They go back in at the lowest grade of salary (paid less than a nurse who has just come out of university with no real experience). The opinion was that reregistered midwives should automatically start at Level II.

Country midwifery is very stressful. Midwives have to make decisions and take responsibility. In country hospitals they make decisions which they would not do in Perth.

Neonates

If there is a neonatal problem and no paediatrician available, it takes three hours for the Flying Squad to come from Perth. The delay is in obtaining staff to come down to Pinjarra.

The Committee was told it was better when the doctor would go in an ambulance with the child and they used to meet the Flying Squad at the carpark at Armadale/Kelmscott Hospital. The child would be in the paediatrician's hands within an hour. However, expert advice suggests it is safer for them to come all the way but it is very difficult for the staff in Pinjarra.

Practice Guidelines

There is a problem that guidelines affecting the approach to management of obstetric cases which applies to midwives as well, come from KEMH. At KEMH they practice high-risk, traumatic obstetrics. Yet, if the hospital issues guidelines about procedures, "we" would be crazy not to follow these guidelines in the current medico-legal climate. This has an impact on how obstetrics is practised. It may be that the impact on the whole is a good one but nevertheless there is no input from country GPs, from midwives practising normal obstetrics, or from anybody other than the professorial unit at KEMH.

It would help if formal training in "normal" obstetrics was set up by KEMH or the WA Centre for Remote and Rural Medicine.

Homebirths

The Committee was told that local GP obstetricians do not support home deliveries.

There has only been one application for accreditation of an independent midwife. It was turned down on the advice of the Pinjarra (Murray) District Hospital Medical Advisory Committee.

KALGOORLIE

The Committee visited Kalgoorlie on 7 - 8 March 1995. During that time Members had a tour of the maternity facilities at Kalgoorlie Regional Hospital and met with health professionals,
community groups and members of the public.

In 1993, there were 741 confinements at Kalgoorlie Regional Hospital. It has four delivery rooms and women are encouraged to think about what they would like to do during labour. There is one obstetrician in Kalgoorlie and 12 GP obstetricians.

A number of themes emerged during the Committee's visit.

**Professionals Working in Maternity Services**

There appears to be good co-operation between the obstetrician, GP obstetricians and midwives. In general, the obstetrician tends to handle the complex cases and leaves the more routine deliveries to the general practitioners.

The Committee was told that there is a great level of expertise in Kalgoorlie and that experienced medical staff and midwives make a huge difference to the level of intervention.

**Aboriginal Birthing Centre**

The Committee heard about the proposal to establish an Aboriginal Birthing Centre at Kalgoorlie Regional Hospital. Many people told the Committee that there had been inadequate consultation with the community and professional groups about the centre. There were concerns about staffing, safety, whether women would give birth there or transfer to the hospital during labour, and whether it would be restricted to Aboriginal women only.

**Unique Problems for Women of Kalgoorlie**

The problems associated with geographical remoteness and isolation were raised. Women are brought to Kalgoorlie from remote communities by the Royal Flying Doctor Service at 36 weeks. Aboriginal women may come at 37-38 weeks.

Many women are alone because their partners are away working. The population of the Region is highly transient, therefore, many people have no extended families.

Most first time mothers are fairly young. However, the number of primiparous women aged 35 years and over is increasing. People are also coming to Kalgoorlie to have their second families.

**Midwives**

The Committee heard that there are problems attracting midwives to Kalgoorlie. Reasons may include a high cost of living and cost of rental accommodation.

The midwives who are working in the hospital are highly motivated. There are five long term midwives. Midwives who come to Kalgoorlie get a lot of experience of "normal" deliveries and it is important that they believe in low intervention childbirth.

Active labour (walking about and keeping active) is very popular in the maternity ward and the midwives try to encourage the doctors to pursue this. Active labour appears to strengthen and empower the mother and labour appears to progress faster.

The Committee was told there was a need for more liaison between midwifery staff and community nursing staff and it was felt that it would be useful for community nurses to go to the maternity wards to meet mothers.
Aboriginal Women

The Committee was told that some Aboriginal women are not allowed to acknowledge that they are pregnant until they are told by significant women, e.g. aunts or until their partner/husband has a dream.

A large number of Aboriginal women are late presenters for their first antenatal check. The Bega Garnbirringu Health Service presented statistics which showed that 30% of women presented after 30 weeks of pregnancy and there was a high incidence of maternity risk factors. These include diabetes, anaemia, smoking, alcohol and other substance abuse, multiparity (having more than five babies), respiratory problems, urinary tract infections and poor standards of living.

Very few Aboriginal women attend hospital antenatal classes. The Committee heard that Aboriginal women should be encouraged and enabled to go through pregnancy in a much healthier state.

The Committee met with the staff and visited the offices of the Ngunytju Tjitji Pirni Program. The program has already established an effective and comprehensive antenatal and postnatal service for Aboriginal women.

Aboriginal women who come to Kalgoorlie from remote areas to have their babies face the problem of having to wait in a hostel or at the hospital until they are due to deliver. An attempt is made to find companions for the women.

The Royal Flying Doctor Service delivers about 50 babies a year to Aboriginal women (about half the number for the Region).

There was discussion about making the hospital environment more culturally appropriate with more Aboriginal staff, traditional food, physical surroundings and access to the outdoors for both mothers and babies.

The Committee heard that Aboriginal women seem to labour very well. They do not need much pain management and the levels of intervention are less than for the non-aboriginal population. Of the Aboriginal women clients of the Bega Garnbirringu Health Service confined during the period from November 1991 to February 1995, 65% had a spontaneous vaginal delivery and only 6.6% had a caesarean section. It was suggested that there may be less intervention because the babies are smaller.

Aboriginal health workers visit the women, take responsibility for them and liaise with community nurses.

The Committee received statistics from Kalgoorlie Regional Hospital which have been tabled with the Committee's papers.

SWAN DISTRICT HOSPITAL

The Committee visited Swan District Hospital on 5 April 1995. Following a tour of the hospital, the Committee held a formal hearing with hospital staff, an obstetrician and a GP practising in the area. The transcript of the hearing has been tabled with the Committee's documents. The

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1 Submission 68 - Ms Rosalyn Hurst and Dr Anne Stephens, Bega Garnbirringu Health Service.

2 ibid.
Committee received statistics which have been tabled with the Committee's papers.

**ST JOHN OF GOD HOSPITAL, MURDOCH**

The Committee visited St John of God Hospital, at Murdoch on 26 May 1995 and met with the Chief Executive Officer, the Acting Director of Clinical Services and the Nurse Manager.

The hospital has 30 obstetric beds, four birth suites (including a family birth suite), four neonatal units, one normal nursery, 22 private rooms and four shared rooms of two beds each.

Both obstetricians and GPs deliver at the hospital. Women must be booked into the hospital with a doctor who is accredited to the hospital.

**Intervention**

The Committee heard that there is a high level of intervention at the hospital. Patients demand intervention, particularly those who have had a previous confinement.

Induction is demanded by women but it is also recommended by doctors.

Midwives like to use a Doptone in order to hear the heart. It is practical and it gives reassurance. The Committee heard that CTG makes staff more anxious.

The estimated levels of intervention at the hospital were caesarean section (25%-30%); epidurals (25%-30%), forceps (25%) and induction (22%-25%).

**Staff to Patient Ratio**

In the morning, the ratio is one midwife to six patients, in the afternoon, it is one midwife to seven or eight women and at night, the ratio is one to 10.

The Committee heard that midwives should be allowed to rotate around the different areas in the obstetric unit. However, it was stated that the delivery suite is highly specialised.

**Family Birth Suite (FBS)**

The suite is for uncomplicated deliveries. It has not been used very much in the last ten months. If a woman in the FBS requires an epidural she has to be moved out of the FBS to the labour ward.

**Payments**

Some women choose to pay but most are covered by HBF. The Committee was told that the approximate costs at the hospital were $749 for the delivery and $439 for the room per day.

**Early Discharge**

Some women choose to go home early but many women have no support at home. The hospital liaises with the child health service and a woman is routinely directed to a child health nurse.
Antenatal Education

The hospital runs a series of antenatal classes four times a year, as well as preparation for parenthood and refresher classes. About 80% of women attend refresher or preparation for parenthood classes. Women come to the classes at 32 weeks gestation. The education programs try to cover the range of options for childbirth, side effects, alternative pain management, and epidurals. The midwives thought that women's knowledge of induction is low.

The Committee heard that the hospital sees professional women who may be high achievers and are used to being in control. They tend to feel they should in control during their delivery and if things do not go their way they planned they feel they have failed. The women may be older and more focussed on a perfect outcome and expect the doctor will do everything for them.

There is pressure on staff to document everything. The Committee was also told that the pressure is growing as the number of obstetricians declines. Staff are concerned that medico-legal issues may flow on to the midwives.

Continuity of Care

There is an attempt to get women to talk to the same midwife, and patients may see the same midwife antenatally, during delivery and postnatally. The hospital encourages debriefing. Patients who have a caesarean section are encouraged to see the theatre staff afterwards and to debrief their delivery. The Committee heard that women who have emergency caesarean sections are more likely to get postnatal depression because of lose of control.

Professional Roles and Practices

The practice of individual doctors varies. Women often think the doctor knows best. Women expect to see their obstetrician whenever they want. The Committee was told that there is an exclusive relationship between an obstetrician and a woman which calls for commitment and can affect lifestyle. The role of the midwife is not pushed strongly. Midwives feel like handmaidens.

The Future

The Committee heard from a midwife that it would be good to be able to say to a woman, book in and see a midwife for a low-risk delivery and that there would be a pool of hospital obstetricians who could see a woman if there was a problem.

In the private hospital system, delivery payments could go to the hospital rather than to the obstetrician in order to pay the midwife.

The possibility of midwife delivery is very attractive.

WOODSIDE MATERNITY HOSPITAL

The Committee visited Woodside Maternity Hospital in East Fremantle on 26 May 1995 and met with the Nurse Administrator.

The Committee heard that the hospital has a homebirth philosophy in a hospital environment.
It is a government hospital which caters for both public and private patients. It has 40 maternity beds, several delivery theatres and it provides a caesarean section facility, 24 hours a day. It has a small nursery with four neonatal units and one pulse oximeter. It also provides gynaecological services.

The hospital had 1,051 confinements in 1993 and the majority were spontaneous vaginal deliveries (60%). There is a desire to have 1,200 deliveries a year and the hospital could cope with an extra 400 cases (over the present 1,000) with early discharge. The hospital caters for all women including women from low socio-economic groups and women from non-English speaking backgrounds. The hospital has links with the Multicultural Women's Health Centre.

**Early Discharge**

The hospital offers an early discharge program. Women may leave when they are ready but they have the option to remain if they wish. The average length of stay is 3.5 days. The postnatal domiciliary care policy is if a woman lives close to the hospital, the hospital midwife will visit her. The hospital will try to match up women with a midwife they know.

**Pain Management**

There are a number of different types of pain management available at the hospital, but the hospital does not have the facility for patient controlled analgesia. There is a core of anaesthetists which the hospital can contact and it offers a good epidural service without a roster system. The epidural rate at the hospital was 43.3% in 1993.

**Staff**

There are no doctors employed by the hospital on a sessional basis. Doctors are contracted as visiting medical officers. Women must be booked into the hospital by a medical practitioner, but a midwife is always present at the delivery. The Committee heard that there is collaboration between the doctors and midwives. Midwives will contact the doctor when the woman has gone into labour. The doctor may come in or may let the midwife do the delivery. Women are told that they may be delivered either by a doctor or by a midwife. Over 50% of cases at the hospital are GP managed.

**Community Midwifery**

Midwives in private practice are accredited to the hospital. The Committee heard that midwives doing home deliveries will occasionally bring a patient into hospital for some medical procedures. The women may remain in hospital or return home to deliver.

**Transfers**

Women are transferred to King Edward Memorial Hospital for Women prior to 34 weeks gestation if they are very high-risk, and neonates are transferred to Princess Margaret Hospital.

**Antenatal Education**

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Midwives and physiotherapists conduct antenatal education. Women come to the hospital for a pre-admission interview and a look around.

**Continuity of Care**

Staff rotate though all areas of the hospital and it has always been this way. Some people have unique skills, e.g. breastfeeding. Therefore, it is possible for staff to follow mothers through the hospital.

**GP Numbers**

There has been a decline in the number of GPs practising in the area, from 70 to between 20 and 30.

**The Future**

The Committee heard concerns about the future of the hospital in relation to its role in respect to Fremantle Hospital and the fact that it needs to get more business.

The hospital has been trying to get funding from the Alternative Birthing Services Program.

The Committee received statistics for the hospital which have been tabled with the Committee's papers.

**CAMBRIDGE/OXFORD**

In August 1995, the Hon. Ian Taylor, MLA, visited the Rosie Maternity Hospital in Cambridge. He was supplied with information about maternity services in the United Kingdom. The information has been tabled with the Committee's papers.

One of the main issues discussed was the value of allowing women to carry their own maternity records.

Mr Taylor also met with Professor Iain Chalmers to discuss the Cochrane Collaboration and the Cochrane Pregnancy and Childbirth Database.

**AMSTERDAM**

On 25 July 1995, Committee member Mrs June van de Klashorst met with Prof Dr Treffers, an obstetrician and gynaecologist and Ms Beatrijs Smulders, a midwife, in Amsterdam. She heard that women are central to maternity services in Holland. They are given responsibility and make decisions about the birth.

**Homebirth**

In Holland, 31% of women give birth at home and between 45% and 50% of women would like to do so.

Midwives actively encourage homebirth and the Dutch Government supports the move to encourage all mothers to birth at home. However, homebirth rates are declining by 0.1% per
year. Some women labour at home, choose to go to hospital for the birth, then go home a few hours later. (This is like the Domino scheme referred to in Chapter Five).

**Role of the Midwife**

The midwife is the primary caregiver for the whole pregnancy and after care (6 weeks after the birth) and often the mother does not need to see anyone else. Midwives handle almost all cases but have the ability (passed by law) to refer clients directly to obstetricians at any time throughout the pregnancy or during labour. High-risk cases are referred directly to an obstetrician.

The key is the midwife's ability to determine whether a client is high or low-risk. Mrs van de Klashorst heard that this is essential to the Dutch system and an important issue if the system is to work.

Midwives have a Medical Indicator List which has been put together by obstetricians, GPs and midwives, which is used to assess their clients.

Midwives are involved with GP training and teach them about childbirth.

There is no growing trend for mothers to ask for specialist care. They are generally happy with the current system.

**Role of the GP**

GPs are thought to be the weak link in the maternity care system. They do not receive sufficient training with their medical degree.

**Intervention**

Eight per cent of all women in Holland use pethidine for pain management. The epidural rate is four per cent. There is a slight increase in the number of clients asking for epidurals but midwives do not encourage this. It is not offered or mentioned to the client.

The effect of stress causing longer labour was discussed.

The relationship between non-medical factors and intervention rates was discussed.

The older the obstetrician the more the intervention. The presence of midwives in hospitals reduced intervention. Registrars in training lead to decreased intervention.

Questioning of doctors' practices by midwives leads to decreased intervention rates.

**Midwifery Training**

Midwives in Holland have four years of direct entry midwifery training with an emphasis on homebirths and independent midwifery. There is direct entry training because midwifery is seen as a completely different specialisation from general nursing. Nurses often do not want to become midwives because they believe their general nursing training works against them becoming a good midwife.
Insurance

Sixty eight per cent of Dutch women have private insurance cover. They may refer themselves to a specialist. The remaining 35% are low-income earners and are insured by the Government. They can only be referred to a specialist by a midwife. Because everyone is insured, medical insurance pays for the treatment if there is a problem with a child. It was also felt mothers do not need to sue like in America.

The rate of litigation in Holland is increasing but is still very low (57 reports in 1995). Obstetricians, midwives and GPs all pay insurance cover, but in many cases hospitals also cover births.

Accountability

If obstetricians appear to be doing too many interventions, the local midwives have the right and do meet with the obstetrician concerned to question his/her practices. Obstetricians also have the right to question the abilities of and care provided by midwives. Both sides report that this process works well. It is usually informal but it keeps everyone alert.

Reimbursement

The Government supports midwives by not paying benefits to women who have babies in hospital if it is not necessary. GPs get paid for birthing only in areas where there are no midwives available.
CONSUMER VIEWS OF MATERNITY SERVICES:
A SURVEY FOR MOTHERS
APPENDIX C

DATA FROM THE WESTERN AUSTRALIAN PREGNANCY COHORT (RAINE) STUDY
APPENDIX D

The following tables are taken from *A Guide to Effective Care in Pregnancy and Childbirth.*

**Table 1: Beneficial Forms of Care**

Effectiveness demonstrated by clear evidence from controlled trials.

**BASIC CARE**

Support for socially disadvantaged mothers to improve child care.
Women carrying their case notes during pregnancy to enhance their feeling of being in control.
Pre- and periconceptual folic acid supplementation to prevent recurrent neural tube defects.
Folic acid supplementation (or high folate diet) for all women contemplating pregnancy.
Programs (particularly behavioural strategies) to assist stopping smoking during pregnancy.
Balanced energy and protein supplementation of diet when supplementation is required.
Vitamin D supplementation for women with inadequate exposure to sunlight.
Iodine supplementation in populations with a high incidence of endemic cretinism.

**SCREENING**

Doppler ultrasound in pregnancies at high risk of fetal compromise.

**PREGNANCY PROBLEMS**

Antihistamines for nausea and vomiting of pregnancy if simple measures are ineffective.
Local imidazoles for vaginal candida infection (thrush).
Local imidazoles instead of nystatin for vaginal candida infection (thrush).
Postpartum administration of anti-D immunoglobulin to rhesus-negative women with a rhesus-positive fetus.
Administration of anti-D immunoglobulin to rhesus-negative women at 28 weeks of pregnancy.
Antibiotic treatment of asymptomatic bacteriuria.
Antibiotics during labour for women colonised with group B streptococcus.
Tight as opposed to too strict or moderate control of blood sugar levels in diabetic women.
External cephalic version at term to avoid breech presentation at birth.
Corticosteroids to promote fetal maturation before pre-term delivery.
Offering induction of labour at 41+ weeks gestation.

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CHILDBIRTH

Emotional and psychological support during labour and birth.
Maternal mobility and choice of position in labour.
Agents to reduce acidity of stomach contents before general anaesthesia.
Fetal acid-base assessment as an adjunct to fetal heart monitoring in labour.

PROBLEMS DURING CHILDBIRTH

Free mobility during labour to augment slow labour.
Absorbable instead of non-absorbable sutures for skin repair of perineal trauma.
Polyglycolic acid sutures instead of chromic catgut for repair of perineal trauma.

TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY

Prostaglandins to increase cervical readiness for induction of labour.
Amniotomy plus oxytocin for induction of labour instead of either amniotomy or oxytocin alone.
Vaginal prostaglandin E2 for induction of labour.
Vaginal prostaglandin E2 instead of PGF2α for induction of labour.
Vacuum extraction instead of forceps when operative vaginal delivery is required.
Antibiotic prophylaxis (short course or intraperitoneal lavage) with caesarean section.

CARE AFTER CHILDBIRTH

Use of surfactant for very pre-term infants to prevent respiratory distress syndrome.
Consistent support for breastfeeding mothers.
Personal support from a knowledgeable individual for breastfeeding mothers.
Unrestricted breastfeeding.
Local anaesthetic sprays for relief or perineal pain postpartum.
Cabergoline instead of bromocriptine for relief of breast symptoms in non-breastfeeding mothers.
### Table 2: Forms of care likely to be beneficial.

The evidence in favour of these forms of care is not as firmly established as for those in Table 1.

#### BASIC CARE

- Adequate access to care for all childbearing women.
- Social support for childbearing women.
- Financial support for childbearing women in need.
- Legislation on paid leave and income maintenance during maternity or parental leave.
- Midwifery care for women with no serious risk factors.
- Continuity of care for childbearing women.
- Antenatal classes for women and their partners who want them.
- Advice to avoid excessive alcohol consumption during pregnancy.
- Avoidance of heavy physical work during pregnancy.

#### SCREENING

- Selective use of ultrasound to answer specific questions about fetal size, structure, or position.
- Selective use of ultrasound to assess amniotic fluid volume.
- Selective use of ultrasound to estimate gestational age in first and early second trimester.
- Ultrasound to facilitate intrauterine interventions.
- Ultrasound to determine whether the embryo is alive in threatened miscarriage.
- Ultrasound to confirm suspected multiple pregnancy.
- Ultrasound for placental location in suspected placenta praevia.
- Early second trimester amniocentesis to identify chromosomal abnormalities in pregnancies at risk.
- Genetic counselling before prenatal diagnosis.
- Transabdominal instead of transcervical chorion villus sampling.
- Regular monitoring of blood pressure during pregnancy.
- Testing for proteinuria during pregnancy.
- Uric acid levels for following the course of pre-eclampsia.
- Fundal height measurements during pregnancy.

#### PREGNANCY PROBLEMS

- Antacids for heartburn of pregnancy if simple measures are ineffective.
- Bulking agents for constipation if simple measures are ineffective.
- Local metronidazole for symptomatic trichomonal vaginitis after first trimester.
- Antihypertensive agents to control moderate to severe hypertension in pregnancy.
- Antithrombotic and antiplatelet agents to prevent pre-eclampsia.
- Anticonvulsant agents for eclampsia.
- Screening all pregnant women for blood group isoimmunization.
Anti-D immunoglobulin to rhesus-negative women after any bleeding episode during pregnancy.

Anti-D immunoglobulin to rhesus-negative women after any intrauterine procedure.
Intrauterine transfusion for a severely affected isoimmunized fetus.
Routine screening for and treatment of syphilis in pregnancy.
Rubella vaccination of seronegative women postpartum.
Screening for and treatment of Chlamydia in high prevalence populations.
Caesarean section for active herpes (with visible lesion) in labour with intact membranes.
Prepregnancy counselling for women with diabetes.
Specialist care for pregnant women with diabetes.
Home instead of hospital glucose monitoring for pregnant women with diabetes.
Ultrasound surveillance of fetal growth for pregnant women with diabetes.
Allowing pregnancy to continue to term in otherwise uncomplicated diabetic pregnancies.
Careful attention to insulin requirements postpartum.
Encouraging diabetic women to breastfeed.
Tests for blood clotting defect with severe placental abruption.
Vaginal instead of caesarean delivery for placental abruption in the absence of fetal distress.
Vaginal instead of caesarean delivery of a dead fetus after placental abruption.
Repeat scanning at about 32 weeks for low-lying placenta.
Delaying planned caesarean section for placenta praevia until term.
Caesarean section for placenta praevia covering any portion of the cervical os.
Ultrasound examination for vaginal bleeding of undetermined origin.
External cephalic version for transverse lie at term.
External cephalic version for breech in early labour if membranes are intact.
Corticosteroid administration after prelabour rupture of membranes pre-term.
Vaginal culture after prelabour rupture of membranes pre-term.
Antibiotics for prelabour rupture of membranes with suspected intrauterine infection.
Allowing labour to progress after spontaneous onset in prelabour rupture of membranes pre-term.
Elective delivery for prelabour rupture of membranes pre-term with signs of infection.
Amnioinfusion for fetal distress thought to be due to oligohydramnios in labour.
Short-term indomethacin to stop pre-term labour.
Offering induction of labour as an option after fetal death.
Vaginal prostaglandin E₂ for induction of labour after fetal death.
Prostaglandin analogues for induction of labour after fetal death.

CHILDBIRTH

Respecting women's choice of companions during labour and birth.
Respecting women's choice of place of birth.
Presence of a companion on admission to hospital.
Giving women as much information as they desire.
Change of mother's position for fetal distress in labour.
Intravenous betamimetics for fetal distress in labour to `buy time'.
Woman's choice of position for the second stage of labour or giving birth.
Oxytocics to treat postpartum haemorrhage.
Intramyometrial prostaglandins for severe postpartum haemorrhage.

**PROBLEMS DURING CHILDBIRTH**

Regular top-ups of epidural analgesia instead of top-ups on maternal demand.
Maternal movement and position changes to relieve pain in labour.
Counter-pressure to relieve pain in labour.
Touch and massage to relieve pain in labour.
Attention focusing and distraction to relieve pain in labour.
Music and audio-analgesia to relieve pain in labour.
Epidural instead of narcotic analgesia for pre-term labour and birth.
Amniotomy to augment slow or prolonged labour.
Continuous subcuticular suture for perineal skin repair.
Primary repair of episiotomy breakdown.
Delivery of a very pre-term baby in a centre with adequate facilities to care for immature babies.
Presence of a paediatrician at a very pre-term birth.
Trial of labour after previous lower-segment caesarean section.
Trial of labour after more than one previous lower-segment caesarean section.
Use of oxytocin when indicated after previous caesarean section
Use of epidural analgesia in labour when needed after previous caesarean section.

**TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY**

Assessing the state of the cervix before induction of labour.
Transverse instead of vertical skin incision for caesarean section.
Low-dose heparin with caesarean section to prevent thromboembolism.
Transverse lower-segment uterine incision for caesarean section.

**CARE AFTER BIRTH**

Keeping babies warm immediately after birth.
Prophylactic vitamin K to the baby to prevent haemorrhagic disease of the newborn.
Nasopharyngeal suctioning of infants who have passed meconium before birth.
Presence of someone skilled in neonatal resuscitation at birth of all infants likely to be at risk.
Oxygen for resuscitation of distressed newborn infants.
Cardiac massage for infants born with absent heart beat.
Naloxone for infants with respiratory depression due to narcotic administration before birth.
Encouraging early mother-infant contact.
Allowing mothers access to their own supply of symptom-relieving drugs in hospital.
Consistent advice to new mothers.
Allowing women choice of length of postpartum stay in hospital.
Telephone service of advice and information after women go home from hospital after birth.
Psychological support for women depressed after childbirth.
Encouraging early breastfeeding when mother and baby are ready.
Skilled help with first breastfeed.
Correct positioning of baby at breast for breastfeeding.
Flexibility in breastfeeding practices.
Antibiotics for infectious mastitis in breastfeeding women.
Hospital support programs of care for bereaved parents.
Encouraging parental contact with a dying or dead baby.
Providing parents with prompt accurate information about a severely ill baby.
Encouraging autopsy for a dead baby and imparting results to parents.
Help with funeral arrangements for a dead baby.
Self-help groups for bereaved parents.
Specialist counsellors for parents with prolonged grief reactions.
Table 3: Forms of care with a trade-off between beneficial and adverse effects.

Women and caregivers should weigh these effects according to individual circumstances and priorities.

BASIC CARE

Continuity of caregiver for childbearing women.
Legislation restricting type of employment for childbearing women.

SCREENING

Formal systems of risk scoring.
Routine early ultrasound.
Chorion villus sampling versus amniocentesis for diagnosis of chromosomal abnormalities.
Serum alpha-fetoprotein screening for neural tube defects.
Routine fetal movement counting to improve perinatal outcome.

PREGNANCY PROBLEMS

Screening for toxoplasmosis during pregnancy.
Corticosteroids to promote fetal maturation before pre-term delivery in diabetic women.
Induction of labour for pre-labour rupture of membranes at term.
Betamimetic drugs to delay pre-term delivery for implementation of effective measures.
Oral betamimetics to maintain labour inhibition.
Cervical cerclage for women at risk of pre-term birth.
Betamimetic drugs to stop labour.
Expectant care versus induction of labour after fetal death.

CHILDBIRTH

Continuous EFM plus scalp sampling versus intermittent auscultation during labour.
Mid-line versus mediolateral episiotomy, when episiotomy is necessary.
Prophylactic oxytocics in the third stage of labour.
Active versus expectant management of third stage of labour.

PROBLEMS DURING CHILDBIRTH

Routine preloading with intravenous fluids before epidural analgesia.
Narcotics to relieve pain in labour.
Inhalation analgesia to relieve pain in labour.
Epidural analgesia to relieve pain in labour.
Epidural administration of opiates to relieve pain in labour.
Early amniotomy in spontaneous labour.

TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY

Endocervical versus vaginal prostaglandin for cervical ripening before induction of labour.
Oral prostaglandins for induction of labour with a ripe cervix.
Prostaglandins versus oxytocin for induction of labour.
Regional versus general anaesthesia for caesarean section.
Epidural versus spinal anaesthesia for caesarean section.
Ampicillin versus broader-spectrum antibiotics for caesarean section.

CARE AFTER CHILDBIRTH

Prophylactic antibiotic eye ointments to prevent eye infection in the newborn.
Prophylactic versus 'rescue' surfactant for very pre-term infants.
Table 4: Forms of care of unknown effectiveness

There are insufficient or inadequate quality data upon which to base a recommendation for practice

BASIC CARE

Social support for high-risk women to prevent pre-term birth.
Formal pre-conceptual care for all women.
Fish oil supplementation to improve pregnancy outcome.
Prostaglandin precursors to improve pregnancy outcome.
Changes in salt intake to prevent pre-eclampsia.
Calcium supplementation to improve pregnancy outcome.
Magnesium supplementation to improve pregnancy outcome.
Zinc supplementation to improve pregnancy outcome.
Antigen avoidance diets to reduce risk of an atopic child.

SCREENING

Placental grading by ultrasound to improve perinatal outcome.
Fetal biophysical profile for fetal surveillance.

PREGNANCY PROBLEMS

Acupressure for nausea and vomiting of pregnancy if simple measures are ineffective.
Vitamin B₆ for nausea and vomiting of pregnancy if simple measures are ineffective.
Ginger for nausea and vomiting of pregnancy.
Prostigmine for heartburn of pregnancy if simple measures are ineffective.
Dilute acid or lemon juice for heartburn of pregnancy if antacids do not provide relief.
Increased salt intake for leg cramps.
Progestogens for threatened miscarriage with a live fetus.
Human chorionic gonadotrophin for threatened miscarriage with a live fetus.
Immunotherapy for recurrent miscarriage.
Bed-rest for women with pre-eclampsia.
Plasma volume expansion for pre-eclampsia.
Choice among magnesium sulphate, benzodiazepines, and phenytoin for eclampsia.
Hospitalization and bed-rest for impaired fetal growth.
Abdominal decompression for impaired fetal growth.
Betamimetics for impaired fetal growth.
Oxygen therapy for impaired fetal growth.
Hormone therapy for impaired fetal growth.
Calcium-channel blockers for impaired fetal growth.
Plasma volume expanders for impaired fetal growth.
Prophylactic betamimetics for multiple pregnancy.
Hospitalisation and bed-rest for triplet and higher-order pregnancy.
Treatment of group B streptococcus colonisation during pregnancy.
Antiviral agents for women with a history of recurrent genital herpes.
Routine elective caesarean for breech presentation.
Postural techniques for cephalic version of breech presentation.
Prophylactic antibiotics for pre-labour rupture of membranes at term or pre-term.
Postpartum prophylactic antibiotics after prelabour rupture of membranes.
Home uterine activity monitoring for prevention of pre-term birth.
Bed-rest to prevent pre-term birth.
Magnesium supplementation to prevent pre-term birth.
Calcium supplementation to prevent pre-term birth.
Progestogens to prevent pre-term birth.
Magnesium sulphate to stop pre-term labour.
Calcium antagonists to stop pre-term labour.
Routine cervical assessment for prevention of pre-term birth.
Antibiotic therapy in pre-term labour.
Oxytocin antagonists to stop pre-term labour.
Adding thyrotropin-releasing hormone to corticosteroids to promote fetal maturation.
Sweeping of membranes to prevent post-term pregnancy.
Nipple stimulation to prevent post-term pregnancy.
Induction instead of surveillance for pregnancy at 41+ weeks gestation.

CHILD BIRTH

Routine amnioscopy to detect meconium in labour.
Routine artificial rupture of membranes to detect meconium in labour.
Short periods of electronic fetal monitoring as an admission screening test in labour.
Fetal stimulation tests for fetal assessment in labour.
Maternal oxygen administration for fetal distress in labour.
Routinely repeated blood pressure measurements in labour.
Guarding the perineum versus watchful waiting during birth.
Prophylactic ergometrine + oxygen versus oxytocin alone in third stage of labour.
Early versus late clamping of the umbilical cord.
Controlled cord traction in third stage of labour.
Intraumbilical vein oxytocin for retained placenta.

PROBLEMS DURING CHILDBIRTH

Abdominal decompression to relieve pain in labour.
Immersion in water to relieve pain in labour.
Acupuncture to relieve pain in labour.
Acupressure to relieve pain in labour.
Transcutaneous electrical nerve stimulation to relieve pain in labour.
Intradermal injection of sterile water to relieve pain in labour.
Aromatherapy to relieve pain in labour.
Hypnosis to relieve pain in labour.
Continuous infusion versus intermittent top-ups for epidural analgesia.
Early use of oxytocin to augment slow or prolonged labour.
`Active management' of labour.
Cervical vibration for slow or prolonged labour.
Histoacryl tissue adhesive for perineal skin repair.
Phenobarbitone to the mother to prevent intraventricular haemorrhage in the very pre-term infant.
Vitamin K to the mother to prevent intraventricular haemorrhage in the very pre-term infant.
Caesarean section for very pre-term delivery
Caesarean section for pre-term breech delivery.
Immediate versus delayed cord clamping at pre-term birth.

TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY

Oxytocin by automatic infusion systems versus `standard regimens' for induction of labour.
Use of haemostatic stapler for the uterine incision at caesarean section.
Single-layer versus two-layer closure of the uterine incision at caesarean section.
Systematic versus intraperitoneal prophylactic antibiotics at caesarean.

CARE AFTER CHILDBIRTH

Tracheal suctioning for meconium in babies without respiratory depression.
Routine use of antiseptics for the cord.
Oral proteolytic enzymes for breast engorgement in breastfeeding mothers.
Cabbage leaves for breast engorgement in breastfeeding mothers.
Dopamine agonists to improve milk supply in breastfeeding mothers.
Oxytocin nasal spray to improve milk supply in breastfeeding mothers.
Oral proteolytic enzymes for perineal pain postpartum.
Ultrasound and pulsed electromagnetic energy for perineal pain.
Rubber rings and similar devices to prevent pressure for perineal pain.
Cabergoline versus physical methods of suppressing lactation.
Table 5: Forms of care unlikely to be beneficial

The evidence against these forms of care is not as firmly established as those in Table 6.

BASIC CARE

Reliance on expert opinion instead of on good evidence for decisions about care.
Routinely involving doctors in the care of all women during pregnancy and childbirth.
Routinely involving obstetricians in the care of all women during pregnancy and childbirth.
Not involving obstetricians in the care of women with serious risk factors.
Fragmentation of care during pregnancy and childbirth.
Advice to restrict sexual activity during pregnancy.
Prohibition of all alcohol intake during pregnancy.
Imposing dietary restrictions during pregnancy.
Routine vitamin supplementation in late pregnancy in well nourished populations.
Routine haematinic supplementation in pregnancy in well-nourished populations.
High-protein dietary supplementation.

SCREENING

Routine use of ultrasound for fetal anthropometry in late pregnancy.
Using oedema to screen for pre-eclampsia.
Cold pressor test to screen for pre-eclampsia.
Roll-over test to screen for pre-eclampsia.
Isometric exercise test to screen for pre-eclampsia.
Measuring uric acid as a diagnostic test for pre-eclampsia.
Screening for ‘gestational diabetes’
Routine glucose challenge test during pregnancy.
Routine measurement of blood glucose during pregnancy.
Insulin plus diet therapy for ‘gestational diabetes’.
Diet therapy for ‘gestational diabetes’.
Routine use of Doppler ultrasound screening in all pregnancies.
Measurement of placental proteins or hormones (including oestriol and human placental lactogen).

PREGNANCY PROBLEMS

Calcium supplementation for leg cramps.
Screening for and treatment of candidal colonisation without symptoms.
Screening for and treatment of *Trichomonas* colonisation without symptoms.
Bed-rest for threatened miscarriage.
Diazoxide for pre-eclampsia or hypertension in pregnancy.
Diuretics for pregnancy-induced hypertension.
Hospitalization and bed rest in twin pregnancy.
Cervical cerclage for multiple pregnancy.
Routine caesarean section for multiple pregnancy.
Routine screening for mycoplasmas during pregnancy.
Caesarean section for non-active herpes simplex before or at the onset of labour.
Elective delivery before term in women with otherwise uncomplicated diabetes.
Elective caesarean section for pregnant women with diabetes.
Discouraging breastfeeding in women with diabetes.
Prohibition of oral contraceptives for diabetic women.
Vaginal or rectal examination when placenta praevia is suspected.
X-ray pelvimetry to diagnose cephalopelvic disproportion.
Computer tomographic pelvimetry to predict cephalopelvic disproportion.
Liberal use (pretrail of labour) of caesarean section for macrosomia.
Amniocentesis for prelabour rupture of membranes pre-term.
Prophylactic tocolytics with prelabour rupture of membranes pre-term.
Regular leucocyte counts for surveillance in prelabour rupture of membranes.
Betamimetics for pre-term labour in women with heart disease or diabetes.
Hydration to arrest pre-term labour.
Diazoxide to stop pre-term labour.

**CHILDBIRTH**

Routine withholding food and drink from women in labour.
Routine intravenous infusion in labour.
Routine measurement of intrauterine pressure with oxytocin administration.
Face masks during vaginal examination.
Frequent scheduled vaginal examinations in labour.
Routine directed pushing during the second stage of labour.
Pushing by sustained bearing down during second stage of labour.
Breath-holding during the second stage of labour.
Early bearing down during the second stage of labour.
Arbitrary limitation of the duration of the second stage of labour.
‘Ironing out’ or massaging the perineum during the second stage of labour.
Routine manual exploration of uterus after vaginal delivery.

**PROBLEMS DURING CHILDBIRTH**

Biofeedback to relieve pain in labour.
Sedatives and tranquillisers to relieve pain in labour.
Caudal block to relieve pain in labour.
Paracervical block to relieve pain in labour.
Intrapartum X-ray to diagnose cephalopelvic disproportion.
Diagnosing cephalopelvic disproportion without ensuring adequate uterine contractions.
Relaxin for slow or prolonged labour.
Hyaluronidase for slow or prolonged labour.
Delivery of a very pre-term infant without adequate facilities to care for an immature baby.
Elective forceps for pre-term delivery.
Routine use of episiotomy for pre-term birth.
Trial of labour after previous classical caesarean section.
Manual exploration of the uterus to assess previous caesarean section scar.

TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY

Mechanical methods for cervical ripening before induction of labour.
Relaxin for cervical ripening before induction of labour.
Nipple stimulation for cervical ripening before induction of labour.
Extra-amniotic instead of other prostaglandin regimens for cervical ripening.
Instrumental vaginal delivery to shorten second stage of labour.
Routine exteriorization of the uterus for repair of uterine incision at caesarean section.

CARE AFTER CHILDBIRTH

Silver nitrate to prevent eye infection in newborn babies.
Elective tracheal intubation for very-low birthweight infants who are not depressed.
Routine suctioning of newborn babies.
Medicated bathing of babies to reduce infection.
Wearing hospital gowns in newborn nurseries.
Restriction of sibling visits to babies in hospital.
Routine measurements of temperature, pulse, blood pressure, and fundal height postpartum.
Limiting use of women's own non-prescription drugs postpartum in hospital.
Administering non-prescription symptom-relieving drugs at regularly set intervals.
Nipple shields for breastfeeding mothers.
Switching breasts before babies spontaneously terminate the feed.
Oxytocin for breast engorgement in breastfeeding mothers.
Antibiotics for localized breast engorgement (milk stasis).
Discontinuing breastfeeding for localised breast engorgement (milk stasis).
Combinations of local anaesthetics and topical steroids for relief of perineal pain.
Relying on these tables without referring to the rest of the book.
Table 6: Forms of care likely to be ineffective or harmful

Ineffectiveness or harm demonstrated by clear evidence.

**BASIC CARE**

Dietary restriction to prevent pre-eclampsia.
Antenatal breast or nipple care for women who plan to breastfeed.

**SCREENING**

Contraction stress cardiotocography to improve perinatal outcome.
Nipple-simulation test cardiotocography to improve perinatal outcome.
Non-stress cardiotocography to improve perinatal outcome.

**PREGNANCY PROBLEMS**

ACTH for severe vomiting of pregnancy.
Diethylstilboestrol during pregnancy.
External cephalic version pre-term to avoid breech presentation at birth.
Elective delivery for pre-labour rupture of membranes pre-term.
Ethanol to stop pre-term labour.
Progestogens to stop pre-term labour.

**CHILDBIRTH**

Routine enema in labour.
Routine pubic shaving in preparation for delivery.
Electronic fetal monitoring without access to fetal scalp sampling during labour.
Prophylactic intrapartum amniinfusion for oligohydranmios.
Rectal examination to assess labour progress.
Requiring a supine (flat on back) position for the second stage of labour.
Routine use of the lithotomy position for the second stage of labour.
Routine or liberal episiotomy for birth.
Ergometrine instead of oxytocin in third stage of labour.

**PROBLEMS IN CHILDBIRTH**

Glycerol-impregnated catgut for repair of perineal trauma.
TECHNIQUES OF INDUCTION AND OPERATIVE DELIVERY

Oral prostaglandins for cervical ripening.
Oestrogens for cervical ripening or for induction of labour.
Oxytocin for cervical ripening before induction of labour.

CARE AFTER CHILDBIRTH

Sodium bicarbonate for asphyxiated babies.
Routine restriction of mother-infant contact.
Routine nursery care for babies in hospital.
Antenatal Hoffman's exercises for inverted or flat nipples.
Antenatal breast shells for inverted or flat nipples.
Limitation of suckling time for breastfeeding.
Nipple creams or ointments for breastfeeding mothers.
Routine supplements of water or formula for breastfed babies.
Samples of formula for breastfeeding mothers.
Encouraging fluid intake beyond demands of thirst for breastfeeding mothers.
Combined oestrogen-progesterone oral contraceptives for breastfeeding mothers.
Test weighing of breastfed infants.
Witch hazel for relief of perineal pain.
Adding salt to bath water for perineal pain.
Antiseptic solutions added to bath water for perineal pain.
Hormones for relief of breast symptoms in non-breastfeeding mothers.
Bromocriptine for relief of breast symptoms in non-breastfeeding mothers.
GUIDELINES FOR EXCLUSION AND TRANSFER

A. GENERAL

! Residence outside domiciliary visiting area who do not have access to follow up care, ie., midwife/general practitioner.
! No documented evidence of ante-natal care prior to 24 weeks gestation.
! No evidence of ongoing routine antenatal care.

B. HISTORY

1. Medical

! cardiac disease except uncomplicated mitral valve prolapse.
! Renal disease.
! Psychiatric disorder including puerperal psychosis.
! Haematological including bleeding disorders.
! Essential hypertension*.
! Pulmonary embolism or deep vein thrombosis.
! Epilepsy or seizures or use of anticonvulsant drugs.
! Malignant disease.
! Asthma requiring hospitalisation or steroid therapy other than inhaled steroid therapy in the previous five years.
! Chemical dependency.
! Known bony pelvic deformity.
! HIV positive (with evidence of immunodeficiency)
! Systemic lupus erythematosus.
! Diabetes mellitus.

2. Obstetric

! Parity five or more.
! Previous severe pre-eclampsia or eclampsia in most recent pregnancy.
! Previous abdominal uterine surgery other than caesarean section.
! Previous poor obstetric outcome such as stillbirth, birth asphyxia, shoulder dystocia.
3. **Factors to be assessed individually by Obstetrician**

- Three (3) or more first trimester spontaneous or induced abortions without a subsequent term delivery or midtrimester abortion, induced or spontaneous w/o a subsequent term delivery.
- Previous third stage problems including post partum haemorrhage.
- Infertility requiring surgery or fertility drugs.
- Previous cone biopsy.
- Thyroid disease.
- Previous infant with major congenital anomaly and/or inherited disorder (subject to genetic consultation).
- Atypical red cell antibodies.
- Previous caesarean section.
- Difficult vaginal delivery.

C. **INITIAL EXAMINATION**

1. **Maternal Physical Findings**
   - Obesity/assessed individually.
   - Significant cardiac murmurs.
   - Uterine malformations or myomas, abdominal or adnexal masses.
   - Any major abnormality on initial assessment likely to prejudice outcome.

2. **Laboratory Findings**
   - Major haemoglobinopathy.
   - Active syphilis.
   - Atypical red cell antibodies.

D. **ANTEPARTUM**

1. **Transfer Factors**
   - Inadequate attendance for antenatal care.
   - Major fetal congenital abnormalities.
   - Multiple pregnancy.
   - Antepartum haemorrhage and/or placenta praevia.
   - Pregnancy induced hypertension*.
   - Intrauterine growth retardation.
   - Polyhydramnios or oligohydramnios.
   - Gestational diabetes - diagnosis by glucose tolerance test.
   - Preterm labour or preterm rupture of membranes.
   - Conditions requiring induction of labour.
   - Development of other severe obstetrical, medical and/or surgical problems.
   - Circumstantial factors.
   - Client's request.
   - Pregnancy > 42 completed weeks.

2. **Consultation Factors**
! Anaemia < 10.5 g/l.
! Large for dates.
! Glycosuria on two separate occasions.
! Malpresentation at 36 weeks.
! Developing medical illness.
! Atypical red cell antibodies.

E. INTRA AND POST PARTUM

1. **Transfer Factors**
   ! Acute conditions, eg., intrapartum haemorrhage, prolapsed cord, fetal distress.
   ! Evidence of fetal distress - heart beat abnormality.
   ! Significant meconium.
   ! Development of hypertension* and/or proteinuria.
   ! Evidence of infection.
   ! No suitable progress in labour.
   ! Development of other severe medical/surgical problems.
   ! Genital tract bleeding, requiring further management other than intramuscular oxytocic.
   ! Any problems requiring more than 24 hours post-partum in the Family Birth Centre.

2. **In Addition - Transfer out of the Centre is required for** -
   ! IV therapy with syntocinon infusions.
   ! Epidural anaesthetic.
   ! Cardiotocograph monitoring.

3. **Infant** - Refer to Routine Observations of the Newborn Following Birth
   (3.43.1 (7))

* Hypertension is defined as either -

1. A level of >140/90 on two occasions at least four hours apart, or
2. A rise of >30/15 above booking blood pressure on two occasions at least four hours apart after the twentieth week of pregnancy.

Revised: November 1994.
ESSENTIAL MIDWIFERY INTERVENTION SKILLS

It is a requirement for entry as a student midwife that the student has acquired the competencies of a general nurse. The midwifery student will further develop these competencies in relation to midwifery practice. In addition, competency will be demonstrated in the following Essential Midwifery Intervention Skills.

ANTEPARTUM

1. Confirms diagnosis and assesses progress of pregnancy.

   Includes:
   ! History-taking and interview.
   ! Examination of pregnant woman.
   ! Performing or organising relevant screening tests.
   ! Identification of risk factors.

2. Develops, implements and evaluates a comprehensive care plan.

   Includes:
   ! The essentially normal pregnant woman.
   ! Particpative care for selected high-risk and/or abnormal antepartum woman.
   ! Maintenance of privacy, confidentiality and independence.
   ! Consideration of psychosocial and cultural needs.

3. Promotes and maintains independence by planning and conducting individualised and group teaching covering pregnancy, childbirth and parenthood for the mother and her significant others.

   Includes:
   ! Nutrition.
   ! Self-care.
   ! Infant feeding including promotion of breast-feeding.
   ! Fetal growth.
   ! Relationship changes.
   ! Antepartum exercises.

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1 Submission 19 - Ms Janet Timmins, Professional Projects Officer, Nurses' Board of Western Australia.
LABOUR & BIRTH

1. Assesses woman's physical condition and progress in labour.
   
   **Includes:**
   
   - History taking.
   - Abdominal palpation.
   - Timing of contractions.
   - Maternal observations.
   - Fetal observations.
   - Vaginal examinations.

2. Assesses woman's physical and emotional reaction to labour:
   
   **Includes:**
   
   - Nutritional and fluid requirements.
   - Reaction to pain.
   - Methods of pain relief and its effectiveness.

3. Develops, implements and evaluates a comprehensive care plan involving all stages of labour and birth of the baby (ies).
   
   **Includes:**
   
   - Maintenance of privacy, confidentiality and independence.
   - Consideration of physical and psychosocial needs.
   - Teaching and reinforcing relaxation techniques and breathing patterns.
   - Distinguishing between normal and abnormal progress in labour.
   - Identification of obstetrical emergencies and initiation of appropriate action.

   **Use of:**
   
   - Infusion pump.
   - Doppler.
   - Electrofetal monitoring (EFM).
   - Nitrous oxide and oxygen.

4. Administers immediate care to the newborn.
   
   **Includes:**
   
   - Physical assessment and appropriate intervention.
   - Encouragement of family attachment.
   - Consideration of physical needs.

5. Completes all essential documentation.
Includes:
! Documentation required by Nurses Board Policy Statements.
! Documentation required by Health Act 1911 (Midwives Regulations 1982)

**POSTPARTUM**

1. Measures physical, psychological and sociocultural functioning of woman, reports significant findings; devises, implements and evaluates an holistic care plan.

   Includes consideration of:
   ! Rest and comfort.
   ! Vital signs.
   ! Involution of uterus.
   ! Perineum.
   ! Pain.
   ! Diuresis.
   ! Legs.
   ! Breasts/nipples.
   ! Nutritional status.
   ! Maintenance of privacy, confidentiality and promotes independence and self-care.
   ! Behavioural responses.
   ! Family unit attachment.
   ! Encouragement of self-esteem.
   ! Identification of complications and initiation of appropriate action.
   ! Exercises.

2. Assesses infants physical condition and progress, reports significant findings, plans, implements and evaluates appropriate care.

   Includes:
   ! Physical examination.
   ! Nutritional status.
   ! Behavioural responses.
   ! Individual needs.

3. Promotes and maintains the integrity of the family unit by assessment of needs and implementation of appropriate education.

   Includes:
   ! Rooming in.
   ! Breast and/or formula feeding.
   ! Mothercrafting and family involvement.
   ! Discharge planning.
   ! Family planning counselling.
   ! Fitness therapy.
4. Promotes and maintains support for families with special needs giving consideration to related ethical issues.

Includes:

- Parents of pre-term or sick babies.
- Parents of babies with congenital anomalies or abnormalities.
- Parents with multiple births.
- Single parents.
- Bereaved parents.
- Relinquishing parents.

5. Completes all essential documentation.

Includes:

- Documentation required by Nurses Board guidelines.
- Documentation required by Health Act 1911 (Midwives Regulations 1982).

**NEONATAL**

1. Assesses infants physical condition and progress; reports significant findings; plans; implements and evaluates appropriate care.

Includes:

- Consideration of type of birth and Apgar scores.
- Observation and recognition of need for resuscitation and respiratory support.
- Use of appropriate equipment.
- Maintenance of temperature and respiration.
- Management of nutritional requirements.
- Initiation of breast feeding or suitable alternative.
- Anticipation of potential problems.
- Elimination of hazards - chemical, thermal, microbial, electrical.

2. Recognises and implements appropriate management for babies with special needs.

Includes:

- Pre-term/low birth weight.
- Jaundice.
- Infections.
- Congenital anomalies/abnormalities.
- Birth injuries.
- Metabolic disorders.

Approved by Board 10/90.
Amended (Domains) 9/93.