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Rural Maternity Taskforce
Clinical Excellence Division
Department of Health
via email: Rural_Maternity_Taskforce@health.qld.gov.au

To whom it may concern

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. We are strong advocates for maternity services in Queensland, and the many talented medical officers who work within these services across the state. This submission has been reviewed and approved by a majority of AMA Queensland's council.

In 2016, we released a discussion paper which outlined our main concerns with maternity services in Queensland. This paper dealt with maternity services state-wide, not just in rural and remote areas. A copy of this discussion paper is **attached** to this submission for your information. Many of the concerns we raised in this paper are still relevant today. We maintain that it is important that patients in public hospitals be given access to appropriate medical staff (specialist and GP obstetricians as well as other medical providers such as anaesthetists) as well as midwives. This is especially important given the evidence cited in our 2016 discussion paper that clearly demonstrates the doctor led model used in private hospital labour suites results in a lower perinatal mortality rate than the model used in Queensland public hospitals.

Regarding rural and remote maternity services specifically, AMA Queensland believes that rural and remote Queenslanders deserve access to healthcare that is accessible, appropriate, safe, effective and affordable. Whilst Australia is a safe country in which to have a baby and compares well on a number of international measures, we are concerned about the non-collaborative model of maternity services in Queensland's rural and remote hospitals which does not always meet these criteria. We therefore offer the following comments and advice in what aspects of service delivery Queensland Health may wish to focus on.

Federal Strategic Framework

The review taskforce would be aware of work at a Federal level to develop a national approach to public sector maternity services in Australia. Clearly, the outcome of the Queensland review must be cognisant and feed into the work of the Federal reference group.

Whilst we support and commend the work of this taskforce, we have some concerns about the draft strategic directions which have been developed thus far. We have **attached** a copy of the Federal AMA submission on the national review for the information of the Queensland taskforce as this may be useful when considering its own recommendations and how they might align with any Federal recommendations.

"We believe all Queenslanders deserve the best healthcare……we are all patients"

Ease of Access and Mix of Services in Rural and Remote Areas

AMA Queensland believes it is important that women in rural and remote locations be able to access services as close as possible to where they live. This is especially relevant for Aboriginal and Torres Strait Islander women for whom birthing on country can be very important. This needs to be in context of consideration of the facilities clinical safety and capability framework, patient safety and the employment and retention of appropriate medical, midwifery and theatre staff. Transparent maternity modelling discussions need to be held with the necessary stakeholders (including community) and evaluation of the cost benefit analysis is required to inform these decisions.

There is evidence that closing maternity and birthing services can actually result in poorer health outcomes. For example, extended travel time to access maternity services has been shown to lead to increased rates of mortality and adverse outcomes, underscoring the need for local services to deal with obstetric emergencies.[1] A Canadian study found that even limited birthing services provides women with better health outcomes than no local services at all.[2] The change to a midwifery service model with restricted hours in various centres like Theodore and Chinchilla is problematic as there is ample evidence that perceived low risk pregnancies often turn out to be high risk. In these situations, the first time a doctor sees the patient should not be when labour is obstructed or a severe complication develops or becomes apparent.

AMA Queensland supports the retention of existing services in rural and remote locations wherever possible. Whilst we acknowledge that there may often be a significant cost to the Government in maintaining these services, we believe that there are models which should be explored, which increase patient safety and are both affordable and cost effective. Specifically, this model relies on integrating shared antenatal care with local general practitioners, where they exist and hospital staff.

Our members have provided feedback to us that the shared care model of care with Medical Practitioners has been steadily eroded in rural Queensland hospitals over at least the last ten years. We support more rural generalists with advanced skills to be recruited to the regions, as their particular training and skill mix can be hugely beneficial for the communities they serve.

Furthermore, it is important that these rural doctors be included in the birthing process though a shared care and collaborative model. Specifically, we are calling for VMO and SMO GP obstetricians to be able to provide maternity care in our regional hospitals. This helps to embed a culture of support for the rural GP obstetricians and also allows the senior GP obstetricians to supervise and train the diploma candidates in context. The AMA federally, RACGP, ACRRM and RDAA have publicly supported this in the case of Rockingham in WA, where GPs with significant obstetric skills were being locked out of providing maternity care in this regional centre.

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[1] Ravelli A, Jager K, de Groot M, Erwich J, Rijninks-van Driel G, Tromp M, Eskes M, Abu-Hanna A, Mol B. (2010) *Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands.* BJOG 118:457-465.

[2] Grzybowski S, Stoll K, Kornelsen J. (2011) *Distance matters: a population-based study examining access to maternity services for rural women*. BMC Health Serv Res 11:147.

This model of shared antenatal care, which recognises that rural doctors may well have known the patient for many years and being aware of the patient's entire medical history, allows rural doctors to monitor conditions that may worsen during or as a result of pregnancy that may not usually fall within the usual responsibilities of the hospital obstetric team. In particular, the doctor has a critical role in conveying specific questions and issues regarding pregnancy/delivery risk stratification and a role in monitoring of the pregnancy, in conjunction with the hospital multi-disciplinary team that includes skilled midwives.

Reemphasising the shared model of care with general practitioners would help provide better care to rural maternity patients and their newborns. We strongly caution against the further introduction of midwife-led only caseload models without medical backup. We have feedback from members which indicates this experiment has been trialled and failed in parts of rural and regional Queensland, particularly given the evidence which indicates a doubling of perinatal mortality under this model[3]. AMA Queensland strongly favours collaborative models, such as exists in Goondiwindi, that have served doctors and patients so well, and delivered exemplary safety outcomes for decades.

HHSs should be engaging more Visiting Medical Officer (VMO) Rural GPs with obstetric skills or rural generalists with advanced skills in obstetrics that are working in a private capacity to work alongside the rural generalists working as salaried SMOs in a collaborative arrangement. Whilst we are certain that some HHSs would argue that doing so would be cost prohibitive, it must be remembered that VMO Rural GPs could actually provide more services to the hospital and its patients than obstetrics alone. Their training also allows them to compliment procedural services as required if engaged in a collaborative model of care. The ability of the VMO Rural GP to provide a range of services, (including being part of the on-call roster or covering during hospital doctors' recreation, sick or professional development leave), needed by a local rural or regional hospital would be likely to make their engagement cost-effective.

To help re-enable greater retention of private rural GPs, rural and regional Hospital and Health Services (HHSs) need to ensure that these doctors are actively encouraged to be credentialed and to have admitting rights in rural and regional hospitals, where they exist. Allowing rural GPs to admission rights for their private patients is not universal in Queensland hospitals. AMA Queensland strongly recommends that this decision be reconsidered as it currently disincentivises private rural doctors from staying in the region. Inhibiting such collaborative arrangements will lead to adding to the viability woes of private rural doctors, prevent choice for the community, and develop a culture of separation between the public and private doctors. Failed private practices are already causing a significant financial burden to public hospitals who then need to provide all services.

Birthing services also require well-trained and credentialed rural generalist anaesthetists. AMA acknowledges that such doctors are being trained in Queensland. We make two points here. Firstly these rural generalists anaesthetists must not be allowed to deskill as a result of a low volume of birthing services. A structured and compulsory upskilling program in metropolitan or larger regional hospitals should be mandated as part of their employment and HHSs need to ensure back-filling these doctors during their training absences, so that continuity of birthing

[3] Robson SJ, Laws P & Sullivan EA. Adverse outcomes of labour in public and private hospitals in Australia: a population-based descriptive study. MJA 2009, 190(9): 474-477.

services is not interrupted. Secondly, it is vitally important that where privately practicing rural GPs or Rural Generalists with advanced skills in anaesthesia exist, they should be actively encouraged to work as VMOs to complement the anaesthetic roster and need at the local hospital. Opportunities for private practitioners to upskill from time to time should also be encouraged as part of the retention strategy for the community

Rural and regional hospitals will also need to ensure that their skill mix for suitably trained and experienced nurses is also broadened to beyond midwifery nurses alone. More generalist nurses are needed to complement these services safely and collaboratively. Training programs that upskill nurses for more theatre work should also be made available to help broaden the skill mix available to these hospitals. AMA Queensland is supportive of the expansion of the Rural Generalist Nursing Program.

Finally, we uphold Federal AMA's position that there should be no reduction in the training opportunities for obstetrician and gynaecologist registrars (see **Attachment 02**). Medical registrars need experience caring for mothers and babies throughout pregnancy and beyond, not just at crisis points. Feedback from our members indicates that many city-based registrars would actually welcome the opportunity to work in rural and regional areas to perform this work as it allows them to do a variety of work.

Flying Obstetrician/Gynaecology Service

The Flying Obstetrician and Gynaecology Service (FOG) started in 1988 and was an internationally recognised success story. It provided specialist obstetrics and gynaecology services to the women of western Queensland. Routine flights were made to 24 towns across western Queensland including Mt Isa, Julia Creek, Quilpie and Goondiwindi. The service still operates today and provides colposcopies, ultrasound scans and other gynaecological and obstetric services.

AMA Queensland believes the FOG provides an excellent model for providing services to women in rural and remote parts of the state. The support of fly in specialist staff ensures ongoing education and support for local rural obstetricians as well as anaesthetic and theatre experience for the hospital staff and enables women to access gynaecological surgery, where appropriate, in their home town. This service was extremely popular with O&G training registrars as it provided much needed surgical exposure, which remains an increasing problem in metropolitan hospitals with large numbers of trainees competing for available surgical exposure.

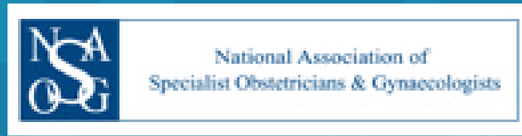
However, AMA Queensland understands that the service is not as robust as it once was, and further investigation into the factors that may have led to this decline is necessary. AMA calls for a new review of the service, to examine ways in which the service could be strengthened and address those factors that may have weakened it.

Once this review has been conducted, and the service has been restored to its former strength, we would advocate for it to be extended or enhanced so as to allow for it to provide services to other communities beyond those it currently operates in, where it is safe to do so.

AMA Queensland thanks you for providing us with the opportunity to provide you with a submission on this consultation paper. If you require further information or assistance in this matter, please contact Jeff Allen, Policy Manager, on 3872 2262.

Yours sincerely

Dr Shaun Rudd
Chair of Board and Council
Australian Medical Association Queensland



Queensland Maternity Services – Discussion Paper

AMA Queensland's Vision for Queensland Public Hospitals

In early June 2016 the Central Queensland Hospital and Health Service report into Maternity Services at Rockhampton Base Hospital (RBH) was released. This independent investigation was commissioned due to several poor outcomes for mothers and neonates in the recent past. There were numerous issues identified particularly in terms of staffing and these issues are common in regional hospitals. There were deficiencies in midwife training, significant cultural issues, poor recognition of deteriorating patients with slow escalation to the obstetrician and a paucity of obstetrician involvement in risk assessment and clinical team leadership.

AMA Queensland believes the results of the Rockhampton Hospital Maternity Service review findings are reflective of long-standing practice challenges faced by maternity services across Queensland. There has been a slow transition to midwifery led practice in recent years with a subsequent reduction in involvement by the obstetrician in public hospitals. It is possible for a mother in a public hospital maternity service to receive all of her antenatal care and management of labour without ever being assessed by a consultant obstetrician. This contrasts with the private sector within which the obstetrician directly manages the care of mothers with more regular review antenatally, during labour and after delivery. This latter practice of obstetrician led care ensures risk is managed appropriately and any co-morbidity or extra precautions to improve patient safety are properly considered.

It is clearly inappropriate for an obstetrician to only be made aware of a labour problem once it has become acute or serious, sometimes many hours after it began to develop. The obstetrician is then expected to assume all responsibility for the care and outcome of the mother and baby. This scenario is reported to be frequent in our public hospitals and results in potential inappropriate delay to definitive care. The current public hospital maternity services model could best be described as midwife-led with obstetrician rescue.

An obstetrician has had broad medical education in addition to their specialty training, spanning over approximately 15 years in total. This has provided an expert clinical and surgical skill set to assist mothers and babies in all clinical scenarios – both normal and abnormal. By contrast, midwifery training has a narrower scope and is significantly shorter. Despite not being as broadly trained in the impact of co-morbidities or complications of pregnancy and not being able to manage all deviations from normal in a pregnant or labouring mother, in public hospitals it is the midwife who is sometimes managing a patient's entire pregnancy and labour. This is a likely causative factor in the differential outcomes recorded between midwifery- and obstetrician-led care.

AMA Queensland believes it is vital that Queensland's expectant parents have confidence in the public hospital system's ability to safely deliver their newborn child into the world. In this submission, we will outline what issues we feel need to be addressed to ensure that confidence is well placed.

Obstetrician-led care versus Public Hospital Midwife-led care

Private hospital labour suites involve a multi-disciplinary model of care, but clinical teams are led by an obstetrician. In addition, the patient is reviewed regularly by the obstetrician throughout the course of their pregnancy and during labour, with the delivery directed by the obstetrician. By contrast, public hospital maternity services are led by midwives and it is possible for a labouring mother to have no obstetrician review unless a midwife requests obstetrician review (which is not mandatory). The marginalisation of the obstetrician in public practice has occurred gradually, but relentlessly over many years. This decreasing direct involvement of the highly trained obstetrician is a significant cause of the inferior outcomes endured by mothers and their babies in public hospital maternity services.

There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospital units, have a significantly higher perinatal mortality rate (2.3/1000) when compared to that of women accessing traditional obstetrician led care (1.2/1000).[1]

The AIHW National Core Maternity Indicators stage 3 and 4 results from 2010-2013[2] identified that amongst women whose birth was considered to be low risk, 25.3% had an assisted (instrumental) delivery in 2013, an increase from 22.8% in 2004. The caesarean rate amongst this same sub-set of mother's was 27.5% and this had similarly increased from 25.3% in 2004. Therefore, critical obstetrician assistance is required in almost half of all births amongst mothers from a low-risk group, and this requirement is increasing. The report suggests this trend might relate to increasing maternal age and pre-existing co-morbidities.

The obstetrician-led model of 'mixed-risk' care is associated with higher rates of obstetric treatments and assistance, but not only did this translate to lower mortality for those babies, as above, obstetrician-led care was also associated with higher (more favourable) Apgar scores[1] at 5 minutes (9.0/1000 obstetric-led care versus 6.7/1000 in midwifery-led care), reflecting improved neonatal health in mixed-risk obstetric-led models of care. In addition, the AIHW National Core Maternity Indicators stage 3 and 4 results from 2010-2013 notes that the proportion of babies born with poor Apgar scores has actually increased from 2010 to 2013 in public hospitals, but has remained stable (and lower) in private hospitals[2]. These favourable outcomes for the obstetrician led care are independent of socioeconomic factors and refute the argument that even perceived low-risk care can be successfully undertaken without obstetrician input.[1]

A recent retrospective study of outcomes in more than 244,000 mothers and term neonates in New Zealand concluded there was excess adverse events in midwife-led deliveries, where midwives practice autonomously, in contrast to medical-led maternity care.[3] Compared to midwife-led care, medical-led care was associated with a substantially lower risk of:

- unfavourable (lower) 5 minute Apgar scores (48% lower)
- birth-related asphyxia (55% lower)
- intrauterine hypoxia (21% lower)
- neonatal encaphalopathy (39% lower).

Medical-led births were also associated with a lower risk of stillbirth and neonatal mortality. In interpreting this data, it should be noted that the model of autonomous midwife-led care is New Zealand that led to this excess of adverse events is very similar to the model of midwife-led care in Australia.

Lessons from the Private Hospital Sector

There is compelling data that the morbidity and mortality rate for mothers and neonates is significantly lower in the private system, where care is led by an obstetrician, as opposed to the public system, where care is led by the midwife with scant involvement of an obstetrician[4,5]. This finding remains significant when adjusted for age, body mass index, co-morbidities and case complexity. According to the Queensland Maternal and Perinatal Quality Council Report 2015, the perinatal mortality rate (7.4 vs 11.1 per 1000 births), still birth rate (5.5 vs 7.4 per 1000 births) and neonatal mortality rate (1.9 vs 3.7 per 1000 births) are all significantly lower in private hospitals as compared to public hospitals[5].

It has been found that rates of obstetric treatments and caesarean sections are higher in private hospitals, as compared to the public system[5,6]. This data is distorted by the previous practice in New South Wales whereby maternal request alone was not an indication for caesarean section, and the significantly higher age of mothers in the private hospital system[5]. The difference in obstetric treatment rates is however logically different between the public and private systems given the involvement of obstetricians who are solely trained to provide this assistance. This same data also shows the superior outcomes for neonates (as determined by the Apgar score, admission to intensive care and neonatal survival) in private hospitals compared to public hospitals. This result has been replicated, and a greater than three-fold increase in 3rd or 4th degree perineal tears in labouring mother's and higher rates of labour/birth complications in the public system compared to private institutions, also highlighted by other authors[5,7].

The higher obstetrician treatment rates found in the private system are therefore related to the improved maternal and neonatal outcomes. This data emphasises the benefit to both women and babies of having care givers who are trained and able to identify complications of pregnancy early and administer appropriate assistance, which in some cases will be life-saving. In other words, the earlier the obstetric involvement, the more timely the assistance, and hence the better the outcome.

The Australian Commission for Safety and Quality in Health Care has published a list of hospital acquired complications[8]. These sixteen complications have been determined for their preventability, as well as their impact on the health service and the patient. Two of the identified complications are perineal tears and birth trauma, both of which have been shown to occur more frequently in public hospital, midwifery led care.

Obstetricians have significantly greater training than midwives, including surgical skills. Therefore, they have a broader and higher level of skills together with experiential insight to achieve the improved outcomes for mother and child. This does not detract from the important work undertaken by midwives in the care of patients, but merely points out the obvious training and role differences that should create a clear difference in clinical responsibilities. The greater training and sole ability of the obstetrician to treat numerous complications of pregnancy necessitates their role as clinical team leaders, as recommended by the RBH report.

What the RBH Report Reveals

The RBH Maternity Services report clearly indicated that there needed to be greater input into a women's care and coordination of multi-disciplinary team efforts by an obstetrician. Many of the recommendations evince a disturbing deviation from good medical practice and reflect a detrimental marginalisation of the obstetrician. Some of the report's key recommendations to note are:

- A nominated consultant must have, as their sole responsibility on an on call day, coverage of Birth Suite and management of acute gynaecological admissions.
- RBH should have multi-disciplinary, up-to-date, evidence based policies that articulate when a woman, whose labour has clearly deviated from normal, needs medical review.
- Antenatal triaging of women to ensure they receive consultant obstetric input as required in a timely way
- Consideration is given to structuring the maternity services in four teams, each one headed by an Obstetric and Gynaecology consultant.

AMA Queensland understands Queensland's Department of Health is considering options to improve the safety and quality of care offered in public hospital maternity departments in this state. As part of this exercise the department is assessing the workforce and workload of each service. There is also an intent to hold a multi-disciplinary forum to allow consultation with senior obstetricians, midwives, and stakeholders.

Proposed Changes to maternity Services Model of Care

AMA Queensland has argued for many years for an improved model of care that allows a leading role and direct involvement of the obstetrician in the management of pregnant and labouring mothers. The evidence, summarised above, suggests this will lead to improved morbidity and outcomes for mothers and neonates in the public hospital system. The five key components of AMA Queensland's suggestions for improvement are:

1. Obstetrician/Obstetric registrar review of all new patients when they visit a public maternity service for their first antenatal visit as a formal and separate encounter before the patient is seen by midwifery staff.
2. Obstetrician/obstetric registrar/resident review of all women on admission to the labour suite, for risk analysis and treatment planning to occur and be documented in the permanent birth record.
3. Obstetrician/obstetric registrar review and examination of all labouring women at least every four hours to assess progress and alter treatment plans according to findings.
4. Restoration/increase of senior salaried (SMO) and visiting medical officer (VMO) consultant obstetrician workforce.
5. Restoration of communication with and involvement of the patient's usual General Practitioner to provide shared care in the community.

1. Obstetrician/Obstetric registrar review of all new patients when they visit a public maternity service for their first antenatal visit.

The initial antenatal visit of a woman at a Maternity service is an important opportunity to assess the possible impact of co-morbidities and risk that might be associated with the ensuing pregnancy. This assessment requires obstetrician involvement but at present this does not always occur and may only occur in a suboptimal, ad-hoc manner. The medical assessment of all new patients referred to a hospital is standard practice in all other hospital departments. Ideally this should be undertaken by a registrar or consultant leading each team of doctors providing care.

The outcome of the first antenatal visit should include a full characterisation of medical risk with any appropriate further testing organised and an appropriate review schedule based on the patient's risk profile established. This may include regular scheduled medical review. This critical initial medical review and planning is an important step in improving patient (mother and baby) safety. Discussion would occur with midwifery colleagues regarding how best to arrange antenatal appointments and what symptoms/findings would trigger additional medical review. It is important to emphasise this practice improvement would involve an obstetrician/obstetric registrar review of the patient's history with physical examination and review of any other relevant results – not just mere supervision or sign-off of midwife assessment. As would be standard, this medical assessment and plan would be communicated with the General Practitioner who is also sharing the care of the patient.

2. Obstetrician/Obstetric registrar/resident review of all women on admission to the labour suite

It is the accepted standard of care that all patients admitted to a public hospital receive medical review and a medical management plan. The only circumstance in which this does not always occur is for admissions to the labour suite. The initial medical assessment is crucial for re-assessing risk to the mother and neonate and for putting in place a management plan and review schedule for the remainder of the labour/admission. There may also be a requirement for further testing or sub-specialty review, which can be organised as part of the admission plan. As above, this practice improvement emphasises the critical importance of medical history taking, physical examination and review of relevant results.

3. Obstetrician/Obstetric registrar review and examination of all labouring women at least every four hours to assess progress

Women admitted to the labour suite are in danger of not having an initial medical review, but have midwifery-led care throughout their labour unless it is realised that there is a complication or obvious difficulty arises. The Rockhampton Hospital Maternity Service review indicated this realisation does not always occur and the training of midwives is not sufficient to appropriately identify, manage and escalate to the obstetricians when patients are deviating from normal.

The philosophy of midwifery is to care for the 'normal' woman during labour and delivery, and trust a woman's body to safely deliver her child. Changes in how obstetric care is administered means that a midwife working in a more independent fashion may become de-skilled over time at recognising deviations from normal progress in early stages, as identified as a concern by the Rockhampton Hospital review team. If only the 'normal' is seen, it may make early recognition of deviations/complications more difficult or impossible, and lead to delay in accessing obstetrician assistance. Compounding this de-skilling of midwives is the very real perception of some midwives that asking for obstetric assistance is seen as a 'failure' and thus seeking this assistance is delayed. The inability to recognise deviations from normal and hesitancy or reluctance to seek specialist obstetrician assistance causes delay in addressing difficulties for mothers or their neonates and allows evolution and in some cases, exacerbation of pathology.

The obstetrician is the only health care profession with the training and experience to identify all complications and difficulties for a labouring mother and to decisively manage them. In order to optimise outcomes for mother and neonate, it is necessary therefore for the obstetrician or obstetric registrar to have regular opportunities to review the labouring mother to examine the patient and assess progress. In the absence of this assessment, it is possible that an obstetrician or obstetric registrar only reviews the patients in order to repair the perineal tear after it has occurred or manage a complication after it has developed and/or become severe, even if earlier treatment could have avoided or minimised the deleterious impact. This is the main reason preventable complications are more frequent and outcomes inferior for mothers and neonates in public hospitals providing midwifery-led care models.

It is proposed that the obstetrician or obstetric registrar review and examine the patient and liaise with the attending midwife at least every four hours during labour. This may need to be more frequent depending on the initial medical assessment and progress of the labour. This recommendation is no different from the immutable expectation of regular medical officer review of medical and surgical patients that occurs throughout the hospital. Other high acuity areas of the hospital such as intensive care unit/coronary care unit have a formalised system of regular reporting and review by medical officers. Similar systems could be introduced into labour wards.

4. Restoration/increase of senior salaried (SMO) and visiting medical officer (VMO) consultant obstetricians

The medical workforce is traditionally comprised of salaried doctors (either full-time or part-time) and visiting medical officers (VMO). Most procedural disciplines have a mix of all types of medical officer employment. VMOs, together with salaried senior medical officers, have an important role in training and education, but also their experience of other workplaces enables easier sharing of process or policy improvements between services. In addition, ensuring an appropriate full complement and mix of senior obstetricians with broad experience means they are uniquely placed to provide advice on what has been successful or not met expectations in comparable institutions. The role of the obstetrician necessarily must be reinstated as the leader of the multidisciplinary team in the proposed model of care for all patients, and may require additional consultant obstetricians to be employed. This will provide the opportunity to build a more diverse, broadly experienced consultant obstetrician workforce.

The VMO perspective across institutions and between the public and private sectors needs to be fostered, in contrast to the recent trends to selectively diminish VMO consultants. Predominant or exclusive employment of full-time salaried senior staff doctors potentially stifles fearless comparison with other services and pursuit of positive reform. Part-time SMOs or VMOs who are not solely dependent on a single hospital or employment source for their income are unencumbered by fear of reprisals or termination should they attempt to draw attention to poor practices or clinical outcomes and improve models of care. An expanded, broadly experienced staff of senior obstetricians comprising both full- and part-time salaried and visiting doctors is therefore ideal.

5. Restoration of communication with and involvement of the patient's usual General Practitioner

As the hospital model of care has migrated away from obstetrician involvement the inclusion of the General Practitioner has also reduced. Anecdotally, General Practitioner's widely report a significant reduction in their involvement in antenatal care of their shared patient and correspondence with the hospital maternity service in regard to the management plan/suggestions. The shared care model of care with the General Practitioner recognises they may well have known the patient for many years and being aware of the patient's entire medical history, are well placed to monitor conditions that may worsen during or as a result of pregnancy that may not usually fall within the purview of the hospital obstetric team. In particular, the General Practitioner has a critical role in conveying specific questions and issues regarding pregnancy/delivery risk stratification and a role in monitoring of the pregnancy, in conjunction with the hospital multi-disciplinary team. Even when an episode of care has previously exclusively involved a midwife, there should still be correspondence back to the General Practitioner.

This care requirement continues into the postpartum period where the majority of care falls into the realm of the General Practitioner who may have received little or no information about the pregnancy and delivery. Most public hospitals in metropolitan areas no longer offer routine postnatal care to women and not all babies delivered are checked by a Paediatrician following delivery (which may be only 2-6 hours postpartum) prior to discharge. This places the burden of postnatal care upon the General Practitioner.

Conclusion

Current evidence and the RBH Maternity Services review suggest there is significant scope to improve the quality of care and outcomes for mothers and neonates in the public hospital system. Critical to achieving this, is a meaningful increase in the early and ongoing medical assessment of pregnant mothers throughout their antenatal care and labour. The proposed initial and regular medical officer review of patients is in line with standard practice in all other disciplines within the hospital. AMA Queensland acknowledges the benefit of multi-disciplinary care and supports this model in maternity practice, However this cannot be achieved without intimate involvement of the obstetrician and medical team, under the leadership of an obstetrician, as recommended by the Rockhampton Base Hospital review.

The shift to midwifery group practice in recent years has paradoxically diminished the role of the obstetrician and led to a clear dichotomy in outcomes between midwifery- and obstetrician-led care. Obstetric leadership of multidisciplinary team care of women in public maternity units in Queensland will allow this detrimental trend to be positively addressed.

AMA Queensland recommends the proposed changes to maternity services be adopted. The National Association of Specialist Obstetrician and Gynaecologists and AMA Queensland are willing to assist the Queensland Government in the implementation of the proposed practice improvements.

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AMA submission: draft Strategic Directions for Australian Maternity Services

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The Australian Medical Association (AMA) welcomes this opportunity to contribute to the development of a national approach to public sector maternity services in Australia.

The AMA commends the work of the Department of Health, the Project Reference Group and the stakeholder advisory group in developing the national strategy to this point. The AMA acknowledges the considerable improvement in the direction, detail and outcomes articulated in the draft circulated for public comment.

The AMA has used the following principles – stated in its previous submissions – as the main measure to assess the draft strategy.

- The primary objective of all maternity services should be healthy mothers and babies.
- Ideology and practitioner-specific agendas should not determine maternity policies and services.
- Policies and services should be evidence-based.
- Policies and services should consider the woman, her baby and family.
- Funding should follow models of care which improve the health and survival of mothers and babies, is cost effective and improves women's experiences.

Using these principles, the AMA still has concerns about specific aspects of the draft which are expanded below.

Section 1.2 Collaboration between health professionals

The AMA recommends an additional practical 'enabler' should be added: embedding electronical and digital communication systems which enhance and streamline the sharing of

information between professionals and settings, with the goal of decreasing time spent on ‘paperwork’ and increasing time spent with women on direct patient care.

Section 2.1 Improving access to continuity of care

Principle

The AMA recommends dropping the word ‘improved’ from the principle ‘Women have improved access to continuity of care with the care provider(s) of their choice’, in order to strengthen and emphasise the intention.

Rationale

The AMA does not support the emphasis on midwife-led continuity of care in this section. The World Health Organisation (WHO) recommendation quoted here arises from a paper focusing on ‘women’s preferences’, which are important but have been considered as part of a bigger picture. Further, the recommendation is taken out of context: the WHO paper is aimed at low to middle income countries in terms of achieving ‘Sustainable Development Goals’ and where access to medical practitioners is limited.

Australian women are fortunate to have subsidised access to highly trained general practitioners (GPs), obstetricians and other medical practitioners, as well as midwives. Australia can do better.

Midwives have a key role to play in maternity services, but this should not be to the exclusion of other health care providers. Regional differences across the country will affect access to different models of care and we should encourage a team-based approach using the strengths of each discipline.

Maternity care services are one part of the ‘life-cycle’ of health services provided to women and their families. Most Australian models of midwife maternity care begin at around 20 weeks gestation to a few days post-partum. Midwives are therefore not in a position to provide continuous care.

Midwife-led continuous care would likely fragment long term care arrangements and may distance the primary care provider, who will have sole responsibility of the longer-term care of both mother and baby after delivery.

GPs are best placed to take the lead in providing continuity of care and are accessible in nearly all parts of Australia. GPs are the key health practitioners, already providing care to women before, during and long after their pregnancies.

GPs are especially crucial in the provision of whole of maternity care for rural and hard to access groups. Strengthening and supporting the role and ability of GPs to be involved in whole holistic maternity care will increase the ability of women to have continuity of care, whole person care and quality maternity care in their community.

The importance of midwives, obstetricians, etc, in the perinatal period should be recognised but the emphasis should be on teamwork and collaboration, consistent with Section 1.2.

Enablers

Regarding the listed 'enablers' in this section, any research on the cost-benefit of different models of care must take into account 'intention to treat'. The cost of care needs to be calculated based on how women were initially assessed, rather than where they end up in the health care system.

Too often, AMA obstetrician members find themselves caring for women who were assessed as low risk or decided to access low risk models of care. High risk features of their health and/or environment were either missed or not disclosed resulting in preterm birth and complications. This results in increased costs to the health care system as well as trauma for a preterm baby, mother and family. Any research comparing different models of care should ensure women in this situation are assessed based on their initial model of care.

Early assessment by an obstetrician or other specialist medical practitioner helps prevent adverse outcomes. This is why, when possible, all women should be assessed by an obstetrician as part of their first antenatal visit to a public sector maternity service. This is supported by the Australian Institute of Health and Welfare (AIHW) 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13, which showed that critical obstetrician assistance is subsequently required in almost half of all births amongst mothers from a 'low-risk' group.

Early assessment by an obstetrician is also supported by independent Queensland Government commissioned reviews. These reviews specifically identified delays in accessing specialist obstetrician input in midwifery models of care in a large public hospital as contributing to a number of adverse outcomes. An explicit recommendation was that obstetricians be involved earlier during both pregnancy and labour.

The description of the 'enabler' regarding research into the cost-benefit of models should be expanded to clarify that research should be conducted into the economic benefits of various models of care, including:

- tracking the initial 'intention to treat' model to the final care actually required,
- the effect of increased private health care to ease the pressure on public hospitals, and
- the costs of adverse outcomes, such as medicolegal and other compensations, and the long-term impact on women and their babies.

Section 2.2 Improving access to maternity care

It is admirable to aim for women-centric services by designing services around the needs of women and communities. The AMA fully supports this goal. However, in achieving this aim, it is also important to acknowledge the needs of the health care practitioners caring for women and their babies. When women cannot or will not leave their community for specialist care, health care workers also suffer when things go wrong, bearing the burden of considerable grief, stress

and medico-legal complexities. Models of health care services need to support health care practitioners as well.

The AMA urges that services also acknowledge the needs and safety of health care workers, who, particularly in rural and remote communities, are also part of the local community.

In relation to the subsection titled 'Improve care in the postnatal period', this is again where the role of GPs is ignored. GPs already provide almost all postnatal care. GPs undertake the 6 week check of mothers and their babies, provide immunisation, contraception, screening and interventions referral. As the average time in hospital after birth is decreasing, women are now seeking advice from GPs much earlier, with issues such as breastfeeding, sleeping and parenting.

Section 3.1 Providing information about local maternity services

The AMA commends the further development of information about maternity services to help women make informed choices. Women should be aware of the full range of care models available in their local area including: midwife services, obstetrician services, shared-care models, GP obstetricians, etc.

In relation to the 'Pregnancy, Birth and Baby' website supported by the Department of Health, the AMA agrees that considerable further work is required before this website could be promoted as a comprehensive source of information about local maternity services. The services currently listed, following local searches, do not reflect the spectrum of services available. Additionally, those services that are listed are not described in a way that allows refinement to maternity services specifically. The Department of Health should work with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), National Association of Specialist Obstetricians and Gynaecologists (NASOG), the Royal Australian College of General Practitioners (RACGP) and other health practitioner groups to improve the website.

Section 3.2 Supporting informed choice

The AMA agrees that 'Having prior knowledge about the risks and benefits of different ways of giving birth enables women to make informed choices during labour'. It is also important to ensure that 'simple to understand' information about models of care is accompanied by a careful assessment of the woman in early pregnancy.

All women should be assessed early in their pregnancy by an obstetrician or GP obstetrician where possible, and provided with ongoing medical monitoring as necessary. This is essential if women are to be fully and comprehensively informed about the potential implications of their health care decisions and the options available to them.

This will ensure that a woman's decision-making about her model of care, is made in the context of her own health and pregnancy and her specific circumstances. The 'simple' information must be personalised so that women can truly make an informed choice.

Having an initial consultation with a medical practitioner also ensures a woman has an opportunity to meet with, and ask questions of, the doctor who may need to respond in a medical emergency. It does not enhance a woman's experience if she only meets an obstetrician or GP obstetrician for the first time in the middle of a deeply personal crisis when complex decisions need to be made.

Section 4.2 Supporting the maternity care workforce

The AMA fully supports the listed 'enabler': 'Support the development of generalists in rural settings to promote the maintenance of services'. This should be one of the highest priorities for governments in order to improve health care in regional and rural communities. Skills maintenance or upskilling of non-urban GPs is the key to safe and effective maternity care for the 25% of women who live outside of our major cities.

Increased support for GP obstetricians should also be a priority. The gradual exclusion of experienced GP obstetricians from rural and regional public hospitals in certain states, only reduces the choice of women in these areas and fragments their care. This is a short-sighted policy that is strongly opposed by the AMA.

It makes no sense for women not to be able to be cared for by the GP obstetrician who has delivered her previous babies, simply because the local hospital no longer 'supports' this model of care.

In addition, regardless of the models of care provided in public hospitals, there should be no reduction in the training opportunities for obstetrician and gynaecologist registrars. Medical registrars need experience caring for mothers and babies throughout pregnancy and beyond, not just at crisis points.

Section 4.3 Supporting safety and quality in maternity care

In addition to 'reducing the still birth rate', it is essential that the draft strategy articulates a 'strategic direction' that 'service providers should maintain low rates of maternal and infant mortality and reduce maternal morbidity'. This is, after all, the ultimate measure of the safety and quality of public sector maternity services in Australia.

State maternal mortality review committees should be supported. Their role should be expanded, to include the review of key measures of maternal morbidity which are also markers of quality health care, such as rates of post-partum depression, 3rd and 4th degree perineal tears, admission to neonatal intensive care units, etc.

Longitudinal research should also be funded and supported to better inform evidence-based maternity care models.

Other issues

There is no mention in the draft document of funding or the impact of insufficient funding on health outcomes. While it may not be possible to mandate minimum funding levels, it should be acknowledged that insufficient financial support for public and private sector maternity services, has a significant impact on women's choices and the quality of care women can access.

State government hospital funding is an ongoing issue. Federal government funding for maternity services has also fallen considerably in real terms. Medicare Benefit Schedule (MBS) rebates for maternity related services should be realistic and adequately indexed to cover the increasing costs now being borne by women themselves. Furthermore, government subsidies for only independently practising midwives must be reviewed, as escalating indemnity insurance for obstetricians and gynaecologists is a main driver of increasing costs which are rising 2-3 times the rate of the consumer price index.

MBS rebates for imaging and pathology associated with maternity care also need urgent attention. These areas of maternity care are rapidly expanding. For example, emerging technologies such as non-invasive prenatal testing and genetic carrier status testing, will identify and help prevent large numbers of chromosomal and genetic disease in children, as well as ultimately saving families and governments significant expenditure.

Increased and sustained funding into women's health is needed for Australian women to continue to enjoy some of the best health outcomes in the world. Both public and private health systems need to be supported, as neither on its own has the capacity to meet demand.

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