AMA Queensland Feedback on QH Queensland Clinical Guideline: Normal Birth v4

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General Feedback

AMA Queensland strongly advocates for clinical guidelines that are evidence-based and consistent with best practice models of care. This is the only means of ensuring patient safety and optimal health outcomes. Clinical guidelines, such as the *Queensland Clinical Guidelines: Normal Birth v4* (the 'Guideline'), that are not based on rigorous science and represent vested interests only serve to place the community at risk and denigrate the reputation of the health profession generally.

AMA Queensland does not support the Guideline. It is distinctly pro-midwife and anti-obstetricians and obstetric treatment. The inclusion of emotive language and selective use of data is unprofessional and dangerous and must be amended to include respectful, neutral terminology and only those treatments which are substantiated by current, rigorous scientific evidence.

After patient safety, informed mother and birth-parent choice must be prioritized over advocacy for a particular method of care and delivery. In advocating for midwife-lead, vaginal delivery without obstetric treatment over other models, the Guideline prioritises ideological values over scientific evidence and threatens the safety of women, birth-parents and babies. It is also likely to lower the public's perception of the professionalism of practitioners and midwives.

Given the increasing failure of public sector maternity services, such as the recent and likely permanent bypass of Gladstone Hospital's maternity unit, now more than ever it is vital that clinical guidelines promote patient safety and choice. The Guideline will force patients who cannot access private obstetric treatment into a single model of care and delivery - midwife-led, vaginal without obstetric treatment.

This perpetuates deep systemic and institutional control and abuse of women by denying women choice over their bodies and reproductive rights. It will also likely harm patients with a history of mental health illness or trauma and transgender men who want a diverse range of models of care. The Guideline must protect and promote the safety and choice of all Queensland women and birth-parents. Currently, it does not.

Inappropriate Terminology

The title 'Normal Birth Guidelines' is not appropriate and must be amended. AMA Queensland suggests 'Vaginal Birth Guidelines'. Similarly, AMA Queensland requests the adoption of neutral terminology throughout the Guideline as outlined in the table below.

Current Inappropriate Terminology	Replacement Neutral Terminology
Normal	Vaginal
Birthing	Birth
Intervention	Treatment

Mothers	Mothers and Birth-Parents, or Patients
Physiological birth	Physiological, unaided birth

Feedback by Section & Page Number

- Flow chart: 'First stage', page 4
    - If a patient declines a vaginal examination at least every four hours, a record must be made in the progress notes. This will assist in identifying patients with obstructed labour that have not been examined but assessed by midwives as progressing without adequate verification.
    - There must be an option for the patient to discuss the starting of syntocinon (i.e. modified induction of labour) as is standard practice in both public and private hospitals. The administration of syntocinon decreases the need for antibiotics which commences following 12-18 hours of ruptured membranes.
- Flow chart: 'Second stage', page 5
    - The flow chart does not document how bladder monitoring is undertaken during the second stage. This must be included.
    - It is unclear from the flow chart if, after an hour of pushing, the midwife would contact the doctor overseeing the labour ward for review on the basis of delay in the passive second stage.
        - If this is the case, AMA Queensland supports this measure and submits that it be made clear in the flow chart. If this is not the case, AMA Queensland requests an explanation and inclusion of this requirement.
        - Further, AMA Queensland requests an explanation as to why there is no comment about delay in the active second stage, as it appears deliberately misleading.
    - Second stage and full dilatation can only be diagnosed on vaginal examination. This is vital to prevent patients pushing on an incompletely dilated cervix. The urge can be quite strong, especially in occipito-posterior labourers and significant issues occur if examination is not undertaken before active pushing commences. It also requires midwives to check for position and station so if a delay in the second stage occurs, the obstetrician is provided some background before the onset of severe moulding, caput and other complications.
- Flow chart: 'Third and fourth stage', page 6
    - If physiological third stage is being undertaken, a record must be made documenting an explanation to the patient of the increased risks of isoimmunisation, post-partum haemorrhage, retained placenta and the need for manual removal of the placenta.
    - Queensland Health must also develop a consent form for this variation given the attendant risks.
    - AMA Queensland requests an explanation as to the absence of carbetocin or syntometrine in the flow chart.
    - AMA Queensland also requests an explanation as to the reason for intramuscular injection if the patient has intravenous access.
- 'Introduction', page 9
    - This section must include patients who request a caesarean section for non-medical reasons, and how the Guideline relates to patients who make this choice. Queensland Health must develop and provide a consent form for patients who request a caesarean section but are refused because it is not supported by the health system.

- ‘1.1 Criteria for normal birth in Queensland’, page 9
    - Recent overseas studies and many organisations have questioned the ongoing prudency of 42 weeks for many patients, particularly those with complex pregnancies and/or 35 years of age and above. AMA Queensland suggests the Guideline is altered to reflect this development.
    - AMA Queensland requests the reasons the administration of an epidural or spinal or artificial rupture of membranes (‘ARM’) are exclusionary criteria. Is this at all stages of labour, or just in later stages (for example, at 10 centimetres dilation; as the baby’s presenting part is being delivered; or in the second twin etc.)?
    - What specific analgesia is permitted under the criteria?
    - What are the reasons other invasive pain relief such sterile water injections are not similarly excluded, since this is also the giving of an agent via injection?
- ‘Supporting normal birth’, page 10
    - AMA Queensland reiterates its comments concerning the use of appropriate terminology including ‘vaginal’ instead of ‘normal’ and ‘obstetric treatment’ instead of ‘birth intervention’. Midwives offer midwifery treatment and obstetricians offer obstetric treatment.
    - AMA Queensland supports the use of “positive language and encouragement, and a flexible approach [to] support the [patient] to feel in control and make informed decisions throughout labour and birth” including supporting the patient and implementing their requests for pain relief (including epidurals or spinals and ARM) and obstetric treatment. To deny the patient’s informed choice and advocate for an alternative method runs against patient-centered and evidence-based models of care.
- ‘Continuity of care’, page 11
    - The phrase ‘continuity of care’ as it is used in the Guideline is not clear. For example, does it include informing patients of:
        - private obstetrician-led continuity of care models;
        - private midwifery continuity of care models;
        - GP-led continuity of care models with in-hospital routine care; and
        - other continuity of care models?
    - International data suggests that whilst some patients report satisfaction with midwife models, patients consistently report high satisfaction with the private obstetrician model which is, at present, the only model that permits a patient to have the same carer complete their care during labour and delivery, regardless of the delivery method that is ultimately required (including vaginal, breech or twins, operative vaginal delivery with vacuum or forceps or caesarean section).
    - Table 3 of the Guidelines is heavily biased towards midwife-led, vaginal delivery without obstetric treatment and undermines the professionalism and integrity of the entire Guideline.
    - Table 4 does not indicate which ‘other models of care’ it is representing. This is unprofessional, lacks scientific rigour and presentation and must be deleted.
    - Table 5 similarly does not indicate if ‘any analgesia/anaesthesia’ includes sterile water injections, gas, physical or diversional therapies or hypno-birth analgesic techniques. It must be amended to include sufficient, clarifying information.

- ‘Birth preparation’, page 12

- In addition to birth preparation empowering the patient to be an active participant in decisions, it must also include fully informing the patient of the risks of physiological unaided birth. AMA Queensland is aware NSW has a special multipage consent form that specifically details the risks of unaided vaginal delivery and calls on Queensland Health to adopt the same measure as part of the Guideline.
- AMA Queensland reiterates its feedback in relation to the second stage as set out under 'Flow chart: 'Second stage', page 5'.
- The provision of information to patients about the various models of care and associated risks and benefits of each is very important. This must be approved by all practitioner groups involved in maternity services and provided in writing with a consent form signed by the patient acknowledging receipt.
- The section on birth plan must specifically include the steps required if a patient changes their mind during labour or delivery. This must include:
    - the case where a patient chooses care not recommended or advised by midwives or obstetricians; and
    - when the patient's preferred choices are deemed unable to be supported or met.

- 'Birth environment', page 13
    - AMA Queensland supports the creation of birth environments based on patient safety and choice. The Guideline must ensure environments are appropriate, particularly where lighting and other preferences may hinder the assessment of blood loss and other birth complications.
- 'Vaginal examination', page 15
    - The first paragraph states there is no need for a vaginal examination if the patient's membranes are intact, however, earlier pages of the Guideline propose a vaginal examination every four hours. This means a patient could labour for many hours without an examination if the membranes remain intact; or the midwife does not appreciate the presence of oligohydramnios or that the membranes had ruptured previously.
    - AMA Queensland suggests, at a minimum, that the Guideline is consistent on the recommended time intervals for vaginal examination.
- '4 First stage', page 16
    - If a patient has ruptured membranes, they require intravenous antibiotics at 14 hours even if in the latent phase due to the risk of infection. Once antibiotics are required, many patients opt for syntocinon infusion to commence. If patients are sent home, it is unclear when the Guideline would recommend they return and how intravenous antibiotics would be given. This must be clearly articulated in the Guideline.
- 'Active first stage', page 17
    - Most obstetric units count active labour as commencing from 4cm dilation. The Guideline statement that some patients 'may not be in active labour before 6cm dilation' is likely to be confusing for some patients.
    - In addition, the next line states patients can self-report active labour, however, the subsequent line states the onset of active labour is 4cm 'and' regular painful contractions.
    - AMA Queensland suggests the Guideline must be consistent and state which criteria will be used to ensure patients can easily understand and self-report.
    - Whilst the Guideline mandates referral once 'deviations from normal' occur, it is unclear of the situation where the patient declines regular examinations or referral. As a

minimum, the Guideline must mandate midwives document deviations, actions taken in response and patient choices in the progress notes when deviations occur.

- 'Ongoing care during first stage', page 18
    - AMA Queensland disagrees that clinical evidence for partograms is low and supports its inclusion as per Table 12.
    - AMA Queensland also reiterates its earlier statements that the Guideline should only include treatments which are supported by rigorous science. Where treatments are not evidence-based, they should not be included at all.
    - Treatments lacking scientific rigour should not be included with a statement to the effect that 'although quality of evidence for clinical benefit is low…' under any circumstances. To do so is unprofessional and undermines the credibility of the Guideline and its proponents.
- 'Delay in active first stage', page 19
    - AMA Queensland again reiterates its comments about appropriate language. It suggests the wording 'if obstetric treatment is required' in place of 'if clinical intervention is required'.
    - The Guideline does not reference the steps to be taken when warning lines on the partogram are crossed. As stated above, AMA Queensland supports the inclusion of partograms in a consistent manner in the Guideline to minimise the risk of creating confusion for patients.
    - Consistent with evidence-based models of care, given the Guideline asserts there is no robust evidence for ARM (although AMA Queensland submits that ARM shortens labour by a very small amount), then the Guidelines should direct care-givers to discuss ARM and advise patients there is insufficient evidence to support its use.
- 'Second stage', page 19
    - It is unclear what is meant by the phrases 'if the baby is visible' and 'expulsive contractions'. These are not commonly used obstetric terms.
    - AMA Queensland submits that the appropriate interpretation is:
        - if the head is on view then the second stage is significantly progressed; or
        - when active pushing occurs (patient-led or directed by midwife/obstetrician) once an urge appears; and
        - until the baby is delivered.
    - The measure of two hours for the diagnosis of delay in nulliparous patients is arbitrary and based on opinion not research. Many institutions use one hour and AMA Queensland submits this as the appropriate measure for inclusion in the Guideline.
- '5.1 Supporting progress toward normal birth', page 20
    - AMA Queensland supports the statement that decisions should not be made according to pre-determined and specified time-limits but rather on the level of exhaustion and other factors as listed, noting that for some patients, one hour can be unduly lengthy.
- 'Birth of baby', page 22
    - AMA Queensland again reiterates that the Guideline must only include treatments that are evidence-based. References to the unsupported 'benefits' of an upright position must be deleted. Its inclusion is unprofessional, misleading and threatens the reputation of midwives and the Guideline's proponents.
    - Similarly, AMA Queensland requests the evidence upon which the Guideline recommends against checking the nuchal cord, particularly in the situation where there

is only intermittent auscultation and pushing with urge only. If it is not supported by the science, then it must be deleted.
    - This also applies to the recommendation for the use of perineal warm compresses. The use of such treatments that are not supported by the evidence should only be included as an option for consideration, rather than recommendations.
    - AMA Queensland rejects the use of the 'hands off technique' and requests it be deleted on the basis that:
        - as stated in the Guideline, it is not supported by the evidence; and
        - at least one tertiary labour ward has reported the 'hands off technique' has been associated with a quadrupling of fourth-degree tears.
- '5.3.1 Water birth', page 23
    - This section must be simplified. There is significant, conflicting data about the safety and usefulness of water birth.
    - In addition, it requires specific equipment (baths, hoists and increased staffing levels to ensure the ability to remove labouring patients from a bath if needed) so individual units must be able to decide whether the increased expenditure is warranted in their health district. They must also follow local, approved guidelines.
    - AMA Queensland suggests most of this section should be removed other than the rows concerning 'facility level systems' and 'informed choice'.
    - Queensland Health must develop a patient consent form that clearly states there are no proven benefits of water birth and that it involves an increased risk of cord avulsion (which appears to have been omitted from the Guideline).
- 'Third stage', page 24
    - AMA Queensland suggests Queensland Health develop a consent form for physiological unaided third stage given it is associated with increased transfusion rates and blood products.
    - AMA Queensland requests an explanation as to how the cord can be left intact when neonatal resuscitation is required and suggests that this is impossible. As such, the Guideline must be amended to indicate that delayed cord clamping is not appropriate for all deliveries.
- 'Ongoing care in third stage', page 25
    - AMA Queensland recommends the inclusion of carbetocin in the third stage, which is gaining popularity for vaginal delivery.
    - AMA Queensland understands there is evidence suggesting Rh isoimmunisation is less frequent when early cord clamping is undertaken. Evidence also shows it reduces the potential for feto-maternal haemorrhage and means less volume of Anti D (an increasingly scarce blood product) is used. Given the need for optimal blood product usage, all practitioners and the Guideline should endeavour to decrease the need for Anti D. One means may be by recommending early cord clamping for Rh negative patients.
    - Oxytocin can also be given intravenously (causing the patient less pain) if they have intravenous access in situ. This should be included in the Guideline.
- '6.1.1 Indications for additional care', page 26
    - AMA Queensland submits that Table 21 must include, as an indication for oxytocin, the patient's desire for decreased blood loss and decreased transfusion risk.
    - In Table 22, AMA Queensland also calls for a recommendation to keep the placenta for histology if, after discussion with a doctor, the baby was assessed as small, the patient

had previously unexplained issues, or the placenta appears to have infarcts, excessive calcification etc.

- 'Requests concerning care of the placenta', page 27
    - AMA Queensland suggests that in the 'Ingestion' row of Table 23, midwives are directed to advise patients that there is presently no commercially-available service that 'encapsulates' in compliance with public health mandates. AMA Queensland understands that companies currently offering this service are operating from domestic kitchens with no oversight for safety. The words 'due to limited research' should be deleted.
    - AMA Queensland rejects the recommendation that a patient be left for an hour after a water birth to suture any tears. This is cruel, inhumane and ignores the fact that the period may be extended if emergencies arise in the labour ward and the doctor cannot see the patient or is delayed.
    - AMA Queensland can only support a one-hour delay if the midwife repairs the tear and is responsible for the repair. In busy labour wards which often only have one resident to repair complex tears, however, this may be counterproductive.