CHAPTER 7

BEST PRACTICE GUIDELINES FOR ANTENATAL CARE AND FOR CARE DURING BIRTH

The current position

7.1 Antenatal care and care during birth are both of a generally high standard for most women in Australia but individual aspects of that care vary considerably in their availability, quality, cost and appropriateness. One of the major determinants of the type and appropriateness of services offered to individual women is the professional background of the person from whom they receive them.

7.2 It is claimed that each of the professional groups has a different emphasis in the services offered. General practitioners and obstetricians generally, as one would expect, have a more medical approach to care than do midwives, who emphasise pregnancy and birth as natural functions requiring minimal intervention in healthy women. The differences in approach can be partly explained by their training. It is also influenced by the fact that medical professionals include within their clientele a higher proportion of at risk women.

7.3 While the emphasis differs **between** professional groups there appear also to be some variations **within** each of these groups. It is difficult to build up an accurate national picture because of the lack of adequate, nationally consistent data on many of the practices associated with antenatal care and care provided during birth. However, the available data from the Australian Institute of Health and Welfare, the Midwives Data Collection, the Health Insurance Commission and the private health funds suggests that practices are determined by individual institutions, by individual practitioners and by the health of individual patients rather than by the State in which they take place.

7.4 Health insurance status has a significant impact on the type and level of care provided during pregnancy and birth. All forms of intervention are higher among women with private health insurance (a position which cannot be justified by the older age of women in this group since they are also generally healthier and better prepared than women without insurance). The differences between insured and uninsured women may also be partly explained by the greater proportion of insured women receiving their care from specialist obstetricians rather than general practitioners or midwives.

7.5 There are major differences in types and levels of care provided to women in rural areas as compared to those elsewhere. Choices are limited in rural areas (although standards of care are not necessarily compromised, as discussed). Women there have fewer interventions, both because specialists are in short supply and because women at risk (for whom an interventionist approach is more appropriate) are transported to urban centres for the birth of their babies.

7.6 In some cases, practice is determined by custom rather than based on evidence, an approach not confined to obstetrics.

> Unfortunately, the introduction of tests into obstetric practice has too often owed more to a process of 'myth and fashion' than to a carefully planned and scientific evaluation of the benefits compared to the costs or hazards.[1]

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> While there have been some studies that have addressed these issues, we generally lack adequate evidence about the effect of what I would say are large uncontrolled experiments in health care.[2]

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> The Royal Women's Hospital like many health care institutions has found that whilst there is substantial evidence available regarding aspects of antenatal care some of the difficulties around developing specific and accepted clinical guidelines in this area have been:
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> - Practice based on history
> - Antenatal care has been largely determined by tradition and training
> - Antenatal care is provided by three different health care professionals – midwives, GPs and Obstetricians, each group having different views on some aspects of the provision of antenatal care.[3]

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> Because there is no universally recognised standard of care, never mind best standard of care, then best practice may be a function of who delivers the care. The consumer has little chance of being able to judge the value, both medically and financially, of interventions suggested by the various possible care givers.[4]

7.7 Several witnesses commented on the significant variations in practice now evident in Australia. These differences cannot be entirely explained by differences in the characteristics of the women involved.

> While there are fixed [antenatal] tests that are considered mandatory for all pregnant women, there are still a number for which there is no clear-cut

1 National Health and Medical Research Council. *Options for effective care in childbirth*, 1996, p.8.

2 *Committee Hansard*, 27.8.99 (Australian Institute of Health and Welfare).

3 Submission No. 46, p.2 (Royal Women's Hospital, Vic).

4 Submission No.104, p.5 (Central Sydney Area Health Service).

> evidence as to what might be regarded as "best practice." In fact, best practice may vary in different parts of the country.[5]

7.8 The Committee concluded on the basis of information obtained during its Inquiry that the standard of care provided to women during pregnancy and birth is generally high. This is particularly the case with respect to maternal and perinatal mortality. However, it considers that the significant variations in practice evident between professional groups, between institutions and within these groups when treating women with similar needs cannot always be explained by reference either to clinical best practice or to evidence based demonstrations of optimal outcomes. To assist in overcoming some of the problems identified in current approaches to practice the Committee supports the development of best practice guidelines for care during pregnancy and birth.

The need for best practice guidelines

7.9 The purpose of best practice guidelines is to improve the quality of health care, to reduce the use of unnecessary, ineffective services or harmful interventions and to ensure that care is cost effective.

7.10 There is widespread interest in their development and implementation, both within Australia and overseas. This interest extends beyond care in pregnancy and childbirth to include all areas of medicine. The reasons for this interest have been succinctly stated by the National Health and Medical Research Council (NHMRC):

> This worldwide interest has been prompted by concern about unjustifiable variations in clinical practice for the same condition, the increasing availability of new treatments and technologies, uncertainty about the effectiveness of many interventions in improving people's health, and a desire to make the best use of available health resources.[6]

7.11 Evidence to the Committee suggested that there was general, but not universal, agreement on the need for best practice guidelines:

> Best practice guidelines are desirable because there is widespread concern about unjustifiable variations in clinical practice for the same condition.[7]

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> I think best practice guidelines are helpful for all clinicians.[8]

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5 Submission No. 5, p.1 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

6 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical best practice guidelines,* Canberra 1999, p.9.

7 Submission No. 109, p.19 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research).

8 *Committee Hansard*, 6.9.99, p.158 (Royal Women's Hospital, Vic).

> Best practice guidelines are desirable and could help ensure national standards are met.[9]
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> The Department of Human Services supports the efforts to increase the promulgation of evidence based practice, and the development of best practice guidelines facilitates this process, with complementary information provided to women. While guidelines on antenatal screening are particularly overdue, national guidelines could usefully be developed across the birthing episode.[10]

7.12 Those who questioned this need did so for a range of reasons. One was the narrow focus of existing work on best practice guidelines, and their failure to acknowledge the emotional aspects of pregnancy and childbirth.

> …Birthplace understands that interventions during childbirth can best be minimised through a thorough reassessment of the nature of ante natal services. Interventions, we believe, *will not* be minimised through "best practice screening standards" *unless* this term is broadened out to include, and respond to, elements beyond the physical condition of the pregnant woman…Best practice screening standards during pregnancy *must* include detecting any emotional, social, psychological and cultural issues which might inhibit a woman's ability to give birth, *if* intervention rates are to decline.[11]

7.13 Another was the perceived danger that they might override clinical judgement.

> When a doctor is confronted by an unprecedented situation, he must be able to work out an appropriate course of action from first principles. The idea that standard management handbooks and so-called "Best Practice" Policies can substitute for clinical judgement is ignorant, naive, and probably partisan.[12]

7.14 A further reason was that guidelines might be 'captured' by a particular group, to the detriment of other groups and individuals.

> Guidelines in public policy have a history of starting out with good intentions. They quickly become controlled by particular professional groups who manipulate them for their own purposes. Their stated purposes are usually couched in terms of beneficial outcomes, community responsiveness, safety, minimum professional standards etc; but history

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9 Submission No. 51, p.12 (Midwifery Practice and Research Centre, NSW).

10 Submission No. 163, p.6 (Department of Human Services, Vic).

11 Submission No. 171, pp.1-2 (Birthplace Support Group Inc).

12 Submission No. 18, p.2 (Dr Ron Chang and others, Qld).

> usually shows that they act to restrict anyone who does not belong to their group or is controlled by their group.[13]

7.15 Those who favoured the development of best practice guidelines stressed the critical importance of ensuring that they were evidence based.

> Best practice guidelines need to be evidence based and developed by practising clinicians informed by national and international research.[14]

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> Many screening practices are not evidence-based, rather have developed historically or from clinician's personal opinions. Guidelines for best practice may well improve this situation and ensure standardisation in many aspects of antenatal care.[15]

7.16 The National Health and Medical Research Council has defined six levels of evidence which are, in order of value:

- evidence obtained from a systematic review of all relevant randomised controlled trials;
- evidence obtained from at least one properly designed randomised controlled trial;
- evidence obtained from well designed pseudo randomised controlled trials, such as alternate allocation;
- evidence obtained from cohort studies, case controlled studies or interrupted time series with a control group;
- evidence obtained from comparative studies with historical control and two or more single arm studies; and
- evidence obtained from a case series, either post test or pre test and post test.[16]

7.17 The evidence based approach represents a departure from the traditional approach to the development of best practice guidelines which was based on consensus among experts. This consensus approach is increasingly discredited.

> Traditionally, guidelines have been based on consensus among experts. But this method has its limitations. Expert opinion does not always reflect the state of current medical knowledge. And, even when guidelines are supported by literature surveys, if the medical literature has been analysed in

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13 Submission No. 147, p.4 (Mr and Mrs J. Wade, Qld).

14 Submission No. 70, p.5 (Royal Australian College of General Practitioners).

15 Submission No. 51, p.4 (Midwifery Practice and Research Centre, NSW).

16 Taken from NHMRC. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1999, p.56.

> an unsystematic way biased conclusions can result. In the past this has led to unnecessary delays in the recommendation of effective interventions and delays in the withdrawal of ineffective or harmful treatments.[17]

7.18 Recognition of the potential of best practice guidelines, and their importance, have long been features of obstetrical medicine, as the Committee was reminded during the Inquiry.

> …obstetrics has led the field in looking for best practice. Obstetrics was the first group of professionals who contributed to the Cochrane Collaboration for evidence based medicine. Obstetrics was first and neonates was second…Best practice is something with which the obstetrical profession and the midwifery profession have been struggling longer than almost any other branch in medicine.[18]

7.19 One of the major factors inhibiting the development of best practice guidelines to date has been the lack of adequate, evidence based research and data on many aspects of care during pregnancy and childbirth. This is particularly the case for evidence based on randomised controlled trials, described repeatedly in the evidence as the most reliable form of research on which to base any standards. Such research would therefore be an essential prerequisite for the development of meaningful and useful guidelines.

7.20 Successive governments, both Commonwealth and State, have failed to implement the recommendations of a range of previous reports advocating the establishment of best practice guidelines and the commissioning of research on which to base them. Evidence to the Committee suggested that work had not proceeded through lack of funding.

7.21 This point was made by Women's Hospitals Australia in relation to antenatal screening guidelines, its work on which has been halted by lack of funding.

> The development and implementation of evidence based standards is significant for a number of reasons:
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> - For the patient, the standards will inevitably mean that an appropriate level of testing is undertaken, and she is subjected only to screening tests that are of proven benefit. In addition, an appropriate level of screening will ascertain any problems with the pregnancy that may need intervention for delivery. Concomitantly, screening may also rule out any need for further intervention.
> - For health service providers, best practice will prevail ensuring efficient and effective use of resources.

17 Ibid, p.10.

18 *Committee Hansard*, 6.6.99, p.162 (Royal Women's Hospital, Vic).

- Funding authorities, ultimately the Commonwealth, will benefit and significant savings will be achieved if the standards are adopted as the norm.[19]

7.22 They were supported by witnesses from the NHMRC's Health Advisory Committee.

> [Women's Hospitals Australia] tried to introduce some regulation on the provision of antenatal surveillance and testing. They tried to do that by seeking our assistance to develop with them guidelines about what should be done in the way of screening and testing of women during pregnancy.
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> …whilst the Health Advisory Committee recommended unanimously that that should be done, it was not possible to find the funds within the department to do it.[20]

7.23 Most witnesses considered that guidelines should be nationally focussed but not prescriptive, to allow practitioners to respond appropriately to the different circumstances in which they operated, and especially to differences in their client groups.

> Best practice guidelines assist in ensuring that certain standards are met and practised throughout Australia in relation to childbirth. However care must be taken to recognise that Australia is a very diverse country and organisations and communities can vary dramatically.[21]
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> I think there also has to be some mechanism built in that women require a variety of services and some women will need more than what is designated as best practice, and there needs to be some flexibility.[22]

7.24 Not everybody shared this view. Some evidence to the Committee suggested that because clinicians' circumstances were so varied, it would be impossible to develop guidelines which would be appropriate for all of them. They therefore considered that guidelines should be developed at the institutional level.

> …I think it [best practice guidelines] should be hospital by hospital. There is so much variation. What is right in a small peripheral hospital would not be right in a tertiary referral hospital.[23]

7.25 The more general view was that guidelines should be national in scope, a view shared by the Committee.

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19 Submission No. 69, p.12 (Women's Hospitals Australia and Australian Healthcare Association).

20 *Committee Hansard*, 14.9.99, p.412 (Health Advisory Committee of NHMRC).

21 Submission No. 48, p.10 (Australian College of Midwives Inc, Goldfields Sub-Branch).

22 *Committee Hansard,* 6.6.99, p.158 (Royal Women's Hospital, Vic).

23 *Committee Hansard,* 6.6.99, p.171 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

The development of best practice guidelines

7.26 There was a strong view in evidence to the Committee that best practice guidelines should be developed primarily by the professionals who will be required to use them. This view is supported by the Committee.

> …I think that it has to be a clinically driven process. It has to be a process in which the stakeholders feel as though they not only have input but some degree of ownership of whatever is the final output.[24]

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> All of the research on behavioural change says that you need to develop the guidelines or ways of doing things with the people who have to implement it.[25]

7.27 Consumer input was also considered important. Not surprisingly, this view was stressed in evidence from consumer groups but it was no by no means confined to them. Many professional groups commented upon the importance of consumer input.

> Best practice guidelines are only desirable and useful if the process clearly invites consumers' final comment of the model developed. A common experience of AIMS members is that we are involved in the process to provide authenticity, but the final model doesn't reflect our concerns.[26]

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> All too often, professionals get together and draw up codes that they think are very relevant but they are not consumer focused. So it requires consultation – and representative consultation – of the people who know what it is all about…[27]

7.28 The importance of consumer input has been recognised in the 1992 NHMRC Act, which obliges the Council to undertake public consultations whenever it is proposing to issue guidelines on any matter falling within its charter.

7.29 Some witnesses suggested that as most consumers lacked the in depth medical knowledge upon which best practice guidelines must necessarily be based their input should be focussed on consumer needs rather than on professional practice.

> If we look at the New Zealand model where consumers have been very strongly part of the movement, the consumer is not involved in looking at

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24 *Committee Hansard,* 27.8.99, p.59 (Women's Hospitals Australia).

25 *Committee Hansard*, 14.9.99, p.421 (Health Advisory Committee of NHMRC).

26 Submission No. 56, p.5 (Association for Improvement in Maternity Services, Qld).

27 *Committee Hansard*, 6.9.99, p.127 (Health Services Commissioner, Victoria).

> the best professional practice; the consumer is there to advise the practice model about what they see as the strongest needs of the consumer.[28]

7.30 Others stressed that input should not be limited to clinicians and consumers but should extend to all key stakeholders.

> There is a great need for the development of current evidence based guidelines for the conduct of all maternity care in Australia. I believe these objectives would best be arrived at by the consensus of groups encompassing equal numbers of consumers, health professionals, local government representatives and other key stakeholders. Such a consensus would allow for socially and culturally sensitive care. It would also be economically efficient because it would address alternative models and reduce costly interventions. All of this would be based on ongoing appropriate research and evaluation.[29]

7.31 The NHMRC also supported an inclusive approach.

> The process of guideline development should be multidisciplinary and should include consumers. If guidelines are to be relevant, those who are expected to use them or to benefit from their use should play a part in their conception and development. Involving a range of generalists and specialist clinicians, allied health professionals, experts in methodology, and consumers will improve the quality and continuity of care and will make it more likely that the guidelines will be adopted.[30]

7.32 The Committee supports the majority view presented in the evidence that best practice guidelines should be national in scope, evidence based and developed by professionals, with significant consumer input. The Committee considers that the Commonwealth should provide a leadership and coordination role in the development of the guidelines, given their national application. The National Health and Medical Research Council (NHMRC) is the most appropriate body to fulfil this function.

7.33 The NHMRC has undertaken extensive work on the development and implementation of general clinical practice guidelines, the results of which were endorsed and published this year, updating an earlier version published in 1995.[31] The NHMRC has demonstrated an awareness both of the potential and of the limitations of best practice guidelines and of the difficulties associated with their implementation and evaluation. It has, through its Health Advisory Committee, instituted a process

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28 *Committee Hansard*, 14.9.99, p.384 (Australian Midwifery Action Project, NSW).

29 *Committee Hansard*, 14.9.99, p.386 (Professor M Chamberlain, University of Sydney).

30 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra, 1999, p.2.

31 See *A guide to the development, implementation and evaluation of clinical practice guidelines,* referred to above. Other NHMRC publications on related topics include, for example, the *Report of the Health Care Committee Expert Panel on Perinatal Morbidity,* 1995, which discussed best practice in prevention and management of perinatal morbidities and *Care around Preterm Birth – Clinical Practice Guidelines.*

whereby guideline development can be scrutinised. This involves public consultations. Its guidelines are evidence based and subject to numerous peer reviews, as well as public involvement.

7.34 The NHMRC has also undertaken some preliminary work on the development of best practice guidelines in antenatal care. These were published in 1988 but have not been generally adopted and have since been withdrawn by the NHMRC for modification and updating in the light of more recent research findings. They have been used in Victoria where their recommendations on antenatal testing and investigation have been adopted, in modified form, by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The Victorian adaptation of the guidelines has been distributed to all practising obstetricians and midwives in Victoria.

7.35 Work is currently being undertaken in a number of institutions and organisations throughout the country on the development of best practice guidelines in antenatal care. Examples brought to the Committee's attention include the collaborative effort between the Southern Health Care Network, the Mercy Maternity Hospital and the Royal Women's Hospital in Victoria to develop evidence based consensus guidelines on antenatal care as it applies to the particular demographic populations served by their organisations. It was also advised of work by Women's Hospitals Australia (now suspended through lack of funding by the Commonwealth Department of Health and Aged Care) to develop guidelines for antenatal care and screening aimed at rationalising services and reducing unnecessary costs. The Committee commends these efforts to develop guidelines which could form the basis for wider dissemination of best practice.

7.36 Some individual hospitals are developing their own guidelines, in the absence of more broadly focussed best practice. The Women's and Children's Hospital in Adelaide, for example, has developed protocols for 41 of the conditions associated with pregnancy, labour and childbirth.[32] They were, however, developed on the basis of clinical practice rather than evidence based medicine and did not include significant consumer input. Westmead Children's Hospital has included as part of its policy the use of the best evidence available on the treatment of children.

7.37 The NHMRC, in its work on the development of best practice guidelines, acknowledged that they should not be implemented in isolation from other approaches to improving care.

> Recent research has shown that clinical practice guidelines can be effective in bringing about change and improving health outcomes. But they are just one element of good medical decision making, which also takes account of

32 Women's and Children's Hospital, Adelaide. *Perinatal Protocols and Guidelines for Management,* 1996.

> patients' preferences and values, clinicians' values and experience, and the availability of resources.[33]

The implementation of best practice guidelines

7.38 Difficulties in implementation of best practice guidelines and on compliance with their requirements were generally recognised in evidence to the Committee as potentially serious impediments to the widespread dissemination of best practice.

> I am sure you are aware that current clinical practice lags well behind available evidence for best practice
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> …We are concerned because a wonderful [NHMRC] document for clinicians and consumers entitled *Care Around Preterm Birth* contained a wealth of clinical information, but there was no formal mechanism in place to disseminate those documents…It seems a shame that there was no mechanism in place to disseminate or to evaluate whether the information contained in those booklets was adopted in clinical practice or helped to inform consumers.[34]
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> …the NHMRC is putting in enormous work and public funds to develop some terrific guidelines but the Commonwealth Department of Health and Aged Care seems to sit and wait for that to filter down through the profession. We wonder whether there could be some proactive mechanism at Commonwealth level whereby that information is picked up by the Commonwealth department of health and distributed down through the state departments of health so that the pregnant women actually get their hands on it.[35]

7.39 Few concrete proposals were forthcoming on successful strategies for encouraging implementation and compliance, although witnesses acknowledged the importance of funding incentives to encourage the adoption of agreed best practice guidelines.

> In Australia there is still no well-resourced and well-developed national effort to disseminate and implement best practice guidelines. One way to achieve this would be to explicitly link best practice in pregnancy and childbirth to the operation of the Medicare Benefits Schedule (MBS). For example, last year the Commonwealth established the Medicare Services Advisory Committee (MSAC) to advise on which new and existing medical services should attract funding under the MBS. This is an important initiative, but unfortunately none of the procedures awaiting evaluation are

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33 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1990, p.1.

34 *Committee Hansard*, 14.9.99, p.459 (NSW Pregnancy and Newborn Services Network).

35 *Committee Hansard,* 14.9.99, p.473 (NSW Pregnancy and Newborn Services Network).

> related to obstetrics. To redress this situation, the Commonwealth could support a partnership between MSAC and the Australasian Cochrane Centre. This would potentially be a very effective policy lever to shift the focus of providers towards the provision of more effective evidence-based medicine.[36]
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> …there is no point in having best practice guidelines unless there are incentives for their implementation and real consequences for contraventions.[37]

7.40 The Committee acknowledges the outstanding work of the Cochrane Collaboration, to which its attention has been repeatedly drawn during the course of this Inquiry, and supports Australia's continued participation in its work.

7.41 The limited information available in the literature suggests that Australian obstetricians are well informed about systematic reviews of randomised trials and that they modify their practices accordingly.[38] They are generally much more likely to know about the results of trials and much more likely to use this information than are their United Kingdom counterparts.[39]

7.42 The NHMRC commented that little was known about the relative effectiveness of audit and feedback, as opposed to the views of major opinion leaders, in changing behaviours so as to reflect evidence based practice.[40] Some evidence to the Committee certainly suggested that the views and practices of well respected clinicians could have a significant impact on health outcomes for women within their institutions. (See for example the drop in Caesarean rates at the Queen Elizabeth Hospital in Adelaide from 21.1% in 1989 to 16.6% in 1996 and at the two Geraldton hospitals, described earlier, from 16.5% in 1994-95 to 7.3% in 1998-99.)

7.43 However, the NHMRC tended to the view that in most institutions the power of a single, respected opinion leader to change attitudes and practices was declining.

> The type of person you are describing is usually a full-time person who is dedicated to work in that hospital and is usually involved in teaching and research as well – whether they call them a staff specialist, or an academic

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36 Submission No. 109, pp.19-20 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research.).

37 Submission No. 56, p.5 (Association for Improvement in Maternity Services, Qld).

38 Jordens, Christopher F. C. et al. *Use of systematic reviews of randomised trials by Australian neonatologists and obstetricians.* Medical Journal of Australia 1998, 168, pp.267-270.

39 Paterson-Brown S. *Are Clinicians Interested in Up to Date Reviews of Effective Care?* The British Medical Journal, vol. 307, 4 December 1993, p.1464 and Olufemi A et al. *Physicians' attitude toward evidence based obstetric practice: a questionnaire survey.* British Medical Journal, January 31 1998, vol. 316, p.365.

40 See *Committee Hansard* 14.9.99, p.414.

> and things. I think that for a long time Australian obstetrics has not been driven by that group of people but has been dominated by the visiting medical officer people, who are fee-for-service private practitioners, and causes a lot of the variation.[41]

7.44 By implication, any hope of successfully implementing best practice guidelines would require a systemic approach in addition to reliance upon the foresight and cooperation of individuals.

7.45 A number of witnesses suggested that, if adherence to best practice guidelines were a recognised legal defence, this would be a powerful incentive to their adoption.

> If the Senate Committee or any other body could arrive at "best practice" standards which if adhered to guaranteed a watertight legal defence against allegations of negligence, obstetricians would adopt them overnight.[42]

7.46 The NHMRC does not rule out the use of best practice guidelines as a defence in case of litigation.

> It is certainly possible that guidelines could be produced as evidence of what constitutes reasonable conduct by a medical practitioner. The National Health and Medical Research Council's Health Advisory Committee considers that practitioners who use guidelines will be afforded a measure of protection.[43]

7.47 Other witnesses pointed to existing guidelines which, though probably not having the status to be used as a legal defence, nevertheless assisted clinicians reluctant to undertake procedures for which they could see no clinical justification.

> We have developed, in conjunction with the Royal Women's Hospital, a shared care protocol. In that is detailed the advice about ultrasound, that ultrasound in early pregnancy is only indicated if there is, for instance, significant vaginal bleeding or abdominal pain, so it is done on an indication. In that we state if a routine scan is done then it is best done at 18 to 20 weeks. That protocol has been distributed to all general practitioners. It has now been adopted by Queensland Health as the model for the whole of Queensland…
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> …They [general practitioners] have welcomed this protocol because they say, "Well, it says here it really is not indicated," and that will make it easier for them to order these tests responsibly.[44]

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41 *Committee Hansard*, 14.9.99, p.425 (Health Advisory Committee of NHMRC).

42 Submission No. 34, p.3 (Division of Women's Health and Newborn Care – Westmead Hospital).

43 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1999, p.6.

44 *Committee Hansard,* 15.9.99, p.533 (Mater Misericordiae Mothers' Hospital, Qld).

7.48 However, in the general literature opinion is divided on whether best practice guidelines could assist clinicians in litigation cases or be used against them.

> It is perhaps not surprising that there is a lack of clarity about how CPGs [clinical practice guidelines] may be used in a legal arena. In particular, there is confusion about whether doctors will be more, or less, vulnerable to a successful lawsuit if they follow guidelines or depart from guidelines for sound clinical reasons. Will the guidelines be a shield, enabling doctors to show that they were not negligent because they followed the CPGs? Or will they be a sword, enabling a plaintiff's lawyers to establish negligence in court when they show that the doctor's treatment of the patient departed from the CPG's? How will the courts deal with the fact that proper clinical management of individual patients cannot always be achieved by strict adherence to guidelines?[45]

7.49 Because of concerns by some clinicians about the adoption of the NHMRC's early breast cancer guidelines the National Breast Cancer Council commissioned a paper in 1997 on the medico-legal implications of best practice guidelines. It concluded:

> Clinical practice guidelines neither hinder nor encourage litigation directly – they are simply likely to be considered another form of expert evidence; or evidence of practice in a court case.
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> …guidelines can aid the legal process by presenting a clear summary of available evidence, rather than leaving the courts with the responsibility of distilling this information from expert testimony.[46]

7.50 The Committee concluded, on the basis of the evidence received, that there was widespread, but not universal, recognition of the need for the development of best practice guidelines on care during pregnancy and birth. The Committee further concluded that such guidelines would need to be national in scope, developed by medical and midwifery professionals through the auspices of the NHMRC, have significant consumer input and be grounded in evidence based research.

7.51 The Committee acknowledges the significant past and present work undertaken on the development of best practice guidelines. It considers that the immediate focus of new work should be on the development of best practice guidelines for the use of ultrasound. This is an area in which there is a great deal of concern among practitioners, consumers and government about current practice and where recent and continuing research increasingly indicates that current practices cannot be justified in terms of outcomes or cost effectiveness.

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45 Pelly Janet et al. *Clinical practice guidelines before the law: sword or shield?* Medical Journal of Australia 1998, 169, pp.330-333.

46 Tito F, Newby L. *Medico-legal implications of clinical practice guidelines.* Sydney, National Health and Medical Research Council National Breast Cancer Centre, 1998.

7.52 In the last budget the Government announced a very large increase in health research funding (an additional $614 million over six years). The NHMRC will have a major role in directing these funds to areas of national health priority. Given the lack of evidence based research in all areas of maternal and infant health, and the importance of maternal and infant health to subsequent health status, the Committee considers that a portion of this funding could justifiably be directed to the commissioning of evidence based research and to the development of guidelines based upon it.

Recommendation

The Committee RECOMMENDS that research and guidelines on the use of routine ultrasound in pregnancy be an immediate priority for the National Health and Medical Research Council. An earlier recommendation set out those aspects of routine ultrasound requiring urgent attention.

7.53 A major impediment to the implementation of best practice guidelines for the care of women during pregnancy and childbirth is the current fragmented approach to maternal and perinatal care. There are gaps and overlaps in the care provided by each of the major types of providers (midwives, general practitioners and obstetricians). There are further gaps, but fewer overlaps, between the organisations providing care (community based services, hospital based services and services provided by private clinicians). There are gaps and overlaps between antenatal, intrapartum and post natal care. There are gaps and overlaps between services provided by State governments and those provided by the Commonwealth. Current funding arrangements exacerbate these divisions.

7.54 This fragmentation has significant adverse consequences for the care of women during pregnancy and childbirth (and indeed for health outcomes more generally). It contrasts with the seamless care arrangements said to operate in New Zealand and Holland.

7.55 In recognition of the difficulty of implementing national best practice guidelines in this environment the NHMRC suggested to the Committee that the NHMRC's role should be limited to guideline development, while their implementation should be the responsibility of a national maternity care committee.

> …I think the NHMRC's role is technical. It is technical in its policy advice but the implementation belongs to the world of health departments, policy makers, funders, politicians and clinicians who are employed in services or subject to professional goals.
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> We need a maternity care committee at a national level that is beyond and incorporates state positions and professional positions but that advises the health ministers to that they can make decisions and put in place the sorts of standards that will ensure all Australian women get an opportunity for good care. They are the people who could take the NHMRC guidelines and say

> "These must guide the standard of care in your hospitals that are providing maternity care".[47]

7.56 The NHMRC envisaged the role of such a committee as extending beyond the implementation of best practice guidelines to encompass information dissemination and education and, most importantly, to consideration of means by which funding incentives could be tied to best practice.

7.57 The existing Joint Committee on Maternity Services could form the basis of such a committee, although its membership would need to be expanded to include all professional groups involved in health care provided during pregnancy, childbirth and post natally, as well as consumers. At present its membership is confined to representatives from the Royal Australian College of Obstetricians and Gynaecologists and the Australian College of Midwives Inc and it is largely inactive. An expanded role for the Joint Committee was recommended by the NHMRC in its report *Options for effective care in childbirth.*

7.58 The Committee considers a national maternity committee of the type proposed may have the potential to tackle the systemic problems undermining health outcomes for mothers and babies. It believes such an approach deserves more detailed consideration.

Recommendation

The Committee RECOMMENDS the enhancement of the Joint Committee on Maternity Services to include professional groups involved in antenatal, birth and post natal care as well as consumers. The Joint Committee should have responsibility for advising Ministers on the implementation and evaluation of best practice guidelines in maternal and infant health care and on measures to reduce current fragmentation in the provision of maternal and infant health services.

7.59 The Committee recognises that while best practice guidelines for care during pregnancy and birth can make an important contribution to improved health outcomes for mothers and babies, they are not the only means of doing so. Also important are the dissemination and encouragement of existing best practice, peer review and increased consumer awareness and education.

7.60 These objectives would be assisted if each State Government published a list of all its hospitals at which births took place, with statistics on each of the interventions performed there for public and private patients. Only New South Wales currently does so. Such a report could include explanations and clarifications pointing out, for example, why major tertiary institutions could be expected to have higher intervention rates than other hospitals.

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47 *Committee Hansard*, 14.9.99, p.417 (Health Advisory Committee of NHMRC).

7.61 Such information would assist consumers to make informed choices, and possibly exert a measure of peer pressure. This appears to be happening in some New South Wales hospitals. According to information supplied to the Committee, the Caesarean rate at Sutherland Hospital, for example, dropped from 27% to 10% over an 18 month period 'as a result of a public outcry, following press reports of the high caesarean rate'.[48]

7.62 The Committee was advised that the former Victorian Government was considering such an approach to conform with the requirements of competition policy, one of which is the need to overcome the existing information asymmetry between the consumers and the providers of services.[49] The Committee is disappointed to note that the former Victorian Government was persuaded to the adoption of such an approach through the demands of competition policy rather than by any concern for improvements to medical practice.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure the annual publication of a list of all of its hospitals where births take place, with statistics on each of the birth-related interventions performed there and the insurance status of the women on whom they are performed.

48 In Submission No. 14, pp.10-19 (Australian College of Midwives, Vic).

49 By the Health Services Commissioner, Victoria. See *Committee Hansard*, 6.9.99, pp.129-130.