Australian Government

Department of Health and Ageing

A/g DEPUTY SECRETARY

Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery

Supplementary information to the Senate Community Affairs Committee inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

I am writing to provide supplementary information to the evidence provided to the Senate Community Affairs Committee public hearing, on 17 December 2009, in relation to its inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills.

I will respond to specific questions taken on notice by the Department during the hearing.

Further information regarding the example of a GP who was told he would be denied insurance if entering into a signed agreement with a non-insured privately practising midwife

During the hearing, Senator Adams asked for more information regarding the example of a GP who was told she would be denied insurance if entering into a signed agreement with a non-insured privately practising midwife (CA 73).

Answer:

As indicated by Ms Flanagan, the Department has investigated the particular case mentioned by Senator Adams. The Department is advised that the inquiry was made by a general practitioner member of the Medical Indemnity Protection Society (MIPS) on 7 December 2009. The Department understands the member wanted to know if their current cover would respond to an incident involving them as a medical practitioner and one or more uninsured midwives who were attending a home birth.

The insurer indicated that there is a general requirement for members to have the appropriate recognised qualifications, training and experience for the health services they provide. In this case the member making the inquiry was not covered for obstetrics, so their current cover would not respond.

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Provision of data regarding the costs of maternity services in private hospitals
Senator Siewert requested data be provided around various maternity costs in private hospitals specifically in relation to special care nurseries (CA 75).

Answer:
The average daily Special Care Nursery charge for privately insured patients in private hospitals in 2008-09 was $740, with an average length of stay in a Special Care Nursery of 7 days. This calculation is based on the Hospital Casemix Protocol data collection and excludes cases where the Special Care Nursery charges were bundled with other types of hospital charges and could not be separately identified.

Note that these figures represent a national average for privately insured patients in private hospitals and exclude self-insured patients in private hospitals and all public hospital patients treated in private hospitals.

Provision of the RANZCOG and ACM guidelines
Senator Moore requested that the Department provide both the guidelines from RANZCOG and the guidelines from the midwives (CA 74-75).

Answer:
Copies of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Guideline: *Suitability Criteria for Models of Care and Indications for Referral within and between Models of Care* and the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* are Attachments A and B respectively.

Provision of a diagram showing the Nurse Practitioner Advisory Groups and their responsibilities
Senator Siewert requested a diagram be provided showing the Nurse Practitioner Advisory groups and their responsibilities (CA 69).

Answer:
A diagram showing the Nurse Practitioner Advisory groups and their responsibilities is provided at Attachment C.

I hope that this information is of assistance to the Committee.

Yours sincerely

Ms Rosemary Huxtable PSM
A/g Deputy Secretary

21 January 2010

Attachments:
A. RANZCOG *Suitability Criteria for Models of Care and Indications for Referral within and between Models of Care*
B. Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral*
C. Diagram of Nurse Practitioner Advisory Groups

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New College Statement

Title	**RANZCOG Guideline: Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care**
Statement No.	**C-Obs 30**
Date of this document	**March 2009**
First endorsed by Council	**March 2009**
Next review due:	**March 2012**

1. Introduction

This multidisciplinary guideline has been developed to assist all health professionals in the delivery of best-practice evidence-based maternity care across multiple models of care.

1.1. Health Practitioners providing Maternity Care

General Practitioners, General Practitioner Obstetricians, Midwives, Specialist Obstetricians and Maternal Fetal Medicine Sub-specialists all have much to contribute to safe maternity care. These guidelines have the intention of making optimal and efficient use of the knowledge base, skill set and experience that each of the professional groups provide to maternity care.

In some instances, referral will be required to a Specialist in another discipline such as a Geneticist, Physician, Anaesthetist, Surgeon, Paediatrician, Infectious Diseases Specialist or Psychiatrist. In most circumstances, such referral will be a decision of the primary health care team and will very much depend on the level of the particular expertise required with respect to that available within the team.

1.2. Models of Care

The following models of care are supported:

a. Shared Care Models

i. GP Obstetrician and Hospital Midwives

ii. GP, Hospital Midwives & Specialist Obstetrician or GP obstetrician

b. Team Care Model

i. Hospital Midwives & Specialist Obstetricians within the Public Health System

ii. Hospital Midwives, Specialist Obstetricians and Maternal Fetal Medicine sub-specialist within the Public Health System

c. Private Care Models

i. Private Obstetrician & Private Hospital Midwives

ii. Private Midwife, Private Obstetrician (GP or Specialist) & Hospital Midwives

1.3. Health Care Settings

1.3.1. Maternity Health Care Settings

a. Six Level Classification of Maternity Health Care facilities

Unfortunately, there is a lack of uniformity in the classification of Maternity Health Care Settings across Australia and New Zealand.

Increasingly, a "six level" classification is being adopted as follows:

i. Level 1
Staffing
- Midwives, General Practitioner

Resources
- Suitable for provision of antenatal and postnatal care

ii. Level 2
Staffing
- Midwives, General Practitioner obstetrician

Resources
- Suitable for labour and birth of women identified at lower risk of obstetric complications
- No Special Care Neonatal unit

iii. Level 3
Staffing
- Midwives, GP or Specialist Obstetricians

Resources
- Special Care Neonatal unit but NOT capable of short-term ventilation

iv. Level 4
Staffing
- Midwives, Specialist Obstetricians

Resources
- Special Care Neonatal unit but NOT capable of short-term ventilation

v. Level 5
Staffing
- Midwives, Specialist Obstetricians

Resources
- Special Care Neonatal unit capable of short-term ventilation

vi. Level 6
Staffing
- Midwives, Specialist Obstetricians and Sub-specialist services
- Physician, Genetics, Specialist Haematology availability

Resources
- Neonatal Intensive Care capable of long-term ventilation

b. Three Level Classification of Health Care Facilities

Many institutions still use a "three tier" classification based on available neonatal care:

i. Level 1
Resources
- No Special Care Neonatal unit

ii. Level 2
- Special Care Neonatal unit

iii. Level 3
- NICU

c. Descriptive Classification of Health Care Facilities

These do not translate exactly into the six levels described above but are still useful concepts.

i. Remote or Rural Centres

ii. Provincial Centres

iii. Metropolitan Centres

iv. Tertiary Centres

v. Birth Centres co-located with a facility capable of providing emergency obstetric and neonatal care.

The College does not support *Home Birth* or *'Free-standing' Birth Centres (without adjacent obstetric and neonatal facilities)* as appropriate Health Care Settings. The College acknowledges that a very small minority of women will choose to birth in these centres, even if appropriately informed of the consequences.

1.4. Guideline Flexibility

There is clearly a balance between conformity to the guidelines in the interests of good clinical practice and a need for flexibility in view of a specific or unusual circumstance in the health care environment, and the clinical circumstances of the patient. The principles of patient autonomy which allows the right to accept or refuse medical advice must be factored into any application of guidelines.

Where a guideline is clearly breached, the practitioner must document the reasons for such action and be able to justify such if subsequently required to do so. Where the circumstance is ongoing (e.g. a local health care environment issue), there should be reference to a local hospital or practice guideline

1.5. Informed Consent

These guidelines acknowledge that a woman may choose not to follow a recommended course of action. In *some* circumstances, this will follow the provision of inaccurate or inadequate information. Subtleties of wording or emphasis can be critical in this respect.

Where lack of "informed consent" is the reason given for non-adherence to guidelines, documentation should occur in a way that appropriate clinical audit is able to identify patterns of practice where this may be a repeated problem, perhaps reflecting the nature &/or method of information provision.

Information should always be provided appropriate to the patients' social and cultural background, and in an unbiased manner. Written information is often helpful.

1.6. Guideline Review

The guidelines will be reviewed at three yearly intervals.

Review of specific areas of the guidelines may occur in the interim under the guidance of the Women's Health Committee, with recommendations to Council as deemed necessary.

2. General Principles

2.1. All Models of Care are Collaborative

There is no place in maternity care for "Professional Independence". All providers of maternity care must work collaboratively, recognising the knowledge, skills and experience that each profession is able to bring to maternity care.

Clear decision making processes are required within the collaborating team, recognising both the knowledge, skills and experience brought by each team member and the imperative of a designated clinical leader.

2.2. Timely Consultation & Referral is Imperative

All providers of maternity care believe they are entitled to an early opportunity to avert adverse outcomes, rather than being thrust into a desperate last-minute rescue when referral for emergency consultation has been unnecessarily delayed. Early consultation will not always be possible but must always be sought.

All referrals should be subject to intermittent multidisciplinary audit, to review appropriateness and timeliness of both referral and response, and outcomes for mother and baby.

2.3. Interdisciplinary Harmony

It is important for patients that they have their care in an environment of interdisciplinary harmony. This needs to be a major priority at all levels including the development of Government policy hospital administrative structures and extending to Professional Colleges

Strategies to facilitate interdisciplinary harmony include:

a. Structure maternity care in multidisciplinary teams

b. Encourage team members to work together rather than being separated in place and time.

2.4. Within the same Model of Care or to another Model of care?

Where Consultation can occur within the same Model of Care, disruption will be minimised. This necessitates predetermined policies about which complications can be managed and how that should best occur. This is an inherent advantage of a collaborative model.

3. Indications for Further Assessment

The following represent indications for medical assessment within the Model of Care, where:

- the medical practitioner has not, as yet, seen the patient knowing the particular condition to be present, or
- there has been a change in the nature of severity of the condition

The following coding is used for clinician referral:

G/O: GP (with a recognised postgraduate qualification in obstetrics) or Specialist Obstetrician where a GP with suitable qualifications is not available, referral should be to a specialist Obstetrician

A: Specialist Anaesthetist

P: Specialist Paediatrician

O: Specialist Obstetrician

S: Maternal Fetal Medicine Sub-specialist or Senior Obstetrician at Level VI facility

3.1. Complications in a Previous Pregnancy

	Severity or Examples	Clinician
Obstetric Complications		
Recurrent 1st miscarriage	3 or more	G/O
Midtrimester miscarriage	1 or more	G/O
Placental abruption		G/O
Preterm Delivery, Cervical incompetence, Preterm PROM	< 35 weeks'	O
	35-36.6 weeks'	G/O
Procedures		
Caesarean section		G/O
Manual removal		G/O
Postpartum haemorrhage		G/O

Preterm birth	< 35 weeks	G/O
Shoulder dystocia		G/O
Termination of pregnancy	3 or more	G/O
Medical Complications		
Blood group antibodies		O
Trophoblastic disease		O
Hypertensive disease	Requiring antihypertensive Rx	G/O
Pre-eclampsia	See ASSHP definition	G/O
Eclampsia		O
Malignancy		G/O
Urinary Tract Infection (UTI)	Recurrent	G/O
Herpes genitalis		G/O
Fetal / Neonatal Complications		
Red Cell Iso-immunisation	Incl severe or persistent jaundice	O
Platelet Iso-immunisation (NAIT)	Incl neonatal haemorrhage or excessive bruising	S
Macrosomia	> 90th centile for gestational age	G/O
IUGR	< 10th centile for gestational age	G/O
	< 3rd centile for gestational age	O
Perinatal death		O
Fetal abnormality		G/O
Intrapartum complications		
Complications of anaesthetic		G/O
Complications of other analgesia or sedation		G/O
Obstructed labour		G/O
Shoulder dystocia		G/O
3rd & 4th degree lacerations		G/O
Cervical laceration		G/O
Post partum haemorrhage (PPH)	> 600 mls	G/O
Retained Placenta		G/O
Vaginal laceration		G/O
Puerperal Complications		
Vulval and perineal haematoma		G/O
Breast abscess		G/O
Postnatal depression		G/O
Dyspareunia > 3/12 postpartum		G/O
Urinary Incontinence > 6/52 postpartum		G/O
Faecal Incontinence		G/O

3.2. Clinical Presentations

General		
Acute abdominal pain		G/O
Palpitations	Recurrent, persistent or associated with other symptoms	G/O
Hypertension	>= 140/90 or relative rise >= 30/15	G/O
Proteinuria	> 0.3g / 24 hours	G/O
Morbid obesity	BMI > 35	G/O
Low maternal weight	BMI < 20	G/O
Obstetric - Antenatal		
Uncertain dates in 3rd trimester of pregnancy		G/O
Uterine Fundus Small for dates	Fundal height ≤ 4 cm below expected for gestational age	G/O
Uterine Fundus Large for dates	Fundal height ≥ 4 cm above expected for gestational age	G/O
Oligohydramnios		O
Polyhydramnios		O
Antepartum haemorrhage		O
Reduced fetal movements	More than one presentation with decreased fetal movements and a normal CTG	G/O
Obstetric - Intrapartum		
Fetal heart rate abnormalities		G/O
Intrapartum haemorrhage		G/O
Maternal tachycardia	Persistent & > 110	G/O
Meconium liquor		G/O
Maternal hypotension or shock		G/O
Obstructed labour		G/O
Prolonged first stage of labour	< 1cm / hr in active phase of labour (Cx ≥ 3cm & effaced)	G/O
Prolonged second stage of labour	≥ 2 hours nullipara or ≥ 1 hour multipara	G/O
Pyrexia in labour	> 37.5 °	G/O
Shoulder dystocia		G/O
Obstetric - Postnatal		
Postpartum haemorrhage – primary or secondary		G/O
Puerperal sepsis	Temp > 37.5, maternal tachycardia	G/O

3.3. Medical Complications

Cardiovascular		
Cardiac	Arrhythmia, Cardiac valve disease, Ischaemic heart disease Cardiomyopathy, Congenital cardiac disease	O
Hypertension (incl essential, endocrine, renal)		G/O
Pulmonary hypertension		O
Thromboembolism	E.g. previous DVT, PE	O
Dermatological		
General	Any requiring systemic medication	G/O
Endocrine		
Diabetes	Pre-existing (insulin dependent or non insulin dependent)	O
	Gestational, well controlled on diet	G/O
	Gestational, requiring insulin	G/O
Thyroid disease		G/O
Hypopituitarism		G/O
Prolactinoma		O
Gastroenterological		
Cholelithiasis		G/O
Cholestasis of pregnancy		G/O
Inflammatory bowel disease		G/O
Hepatitis	Acute /chronic	G/O
Oesophageal varices		O
Genetic		
General	Any condition with which the practitioner does not have detailed familiarity	O
Marfans		O
Haematological		
Anaemia	Hb < 90 g/l, not responding to treatment, Haemolytic anaemia, Macrocytic anaemia, Haemoglobinopathy incl Thalassaemia, HbE, Sickle cell disease	G/O
Bleeding disorders	Including Thrombocytopaenia, Von Willebrands	O
Thrombophillia	incl Antiphospholipid	O

	syndrome, Anticardiolipin antibodies, Lupus anticoagulant, hereditary thrombophilia	
Infectious Diseases		
Possibility of acute or chronic Infection	Viral: Rubella, Varicella, CMV, Parvovirus, HIV, Hepatitis (A, B, C, D or E) Bacterial: Syphilis, Tuberculosis, Listeriosis Protozoan: Toxoplasmosis, Malaria	S
Iso-immunity		
Red Cell Iso-immunisation		O
Platelet Iso-immunisation (NAIT)		S
Neurological		
AV malformation, CVA, TIAs		O
Epilepsy		O
Multiple sclerosis		O
Myasthenia gravis		O
Spinal cord lesion		O
Muscular Dystrophy or Myotonic Dystrophy		O
Psychiatric & Chemical Dependency		
Alcohol or drug dependency		O
Psychiatric condition	On medication or unstable condition	O
Nephrological		
Glomerulonephritis, Pyleonephritis, Renal failure of insufficiency, renal abnormality or vesico-ureteric reflux		O
Respiratory Disease		
Asthma		G/O
Asthma - Moderate. - oral steroids on two occasions in last 12/12		G/O
Asthma - Severe - hospitalisation in the last 2 years - any previous admission to intensive care - FEVi < 70% in absence of acute attack, - requiring bronchodilator therapy daily - > 1200 mcg budisonide or equivalent		G/O
Rheumatological		
Connective Tissue Disease incl SLE, Rhematoid Arthritis, PAN, Scleroderma … etc		O

3.4. Obstetric Complications

Antenatal Obstetric Complications		
Multiple pregnancy	Twins or higher order multiples	O
	Twin-Twin Transfusion	S

	Syndrome	
Placenta praevia	≥ 28 weeks' gestation	O
Placental abruption		O
Cervical incompetence		
Preterm labour	34-36.6 weeks'	G/O
	< 34 weeks'	O
Preterm PROM	34-36.6 weeks'	G/O
	< 34 weeks'	O
Term PROM		G/O
Malpresentation	≥ 36 weeks'; breech, transverse, oblique or unstable lie	G/O
Term PROM (Premature rupture of membranes)	≥ 37 weeks' and not in labour	G/O
Prolonged pregnancy	≥ 41 weeks' GA	G/O
Fetal Complications		G/O
Macrosomia	> 90th centile for GA	G/O
IUGR	< 10th centile for GA	G/O
	< 3rd centile for GA	O
Perinatal death		O
Fetal abnormality		O
Intrapartum complications or procedures		
Malpresentation		G/O
Complications of anaesthetic		G/O
Complications of other analgesia or sedation		G/O
Failure to Progress in 1st stage of Labour	Cs dilatation less than 1cm /hr in the active phase of labour	G/O
Failure to Progress in 2nd stage of Labour	> 45 mins in MG, > 1.5 hrs in PG	G/O
Obstructed labour		G/O
Regional Anaesthesia		G/O
Induction or Augmentation of Labour		G/O
Instrumental Vaginal Delivery		G/O
Shoulder dystocia		G/O
3rd & 4th degree lacerations		G/O
Cervical laceration		G/O
Post partum haemorrhage (PPH)		G/O
Retained Placenta		G/O
Vaginal laceration		G/O
Puerperal Complications		
Secondary PPH		G/O
Vulval and perineal haematoma		G/O
Mastitis or Breast abscess		G/O
Postnatal depression		G/O

3.5. Surgical and Gynaecological Conditions

Gynaecological		
Cervical surgery including cone biopsy, laser excision or LLETZ		G/O

Congenital abnormalities of the uterus	Without previous normal pregnancy outcome	G/O
Infertility	IVF or GIFT pregnancy	G/O
Previous uterine surgery	Myomectomy	G/O
	Previous uterine perforation	G/O
Prolapse	Previous surgery grade 3 or 4	G/O
Uterine fibroids		G/O
Vaginal Abnormality	E.g. Septum	G/O
Surgical		
Abdominal trauma		G/O
Appendicitis		G/O

3.6. Anaesthetic Issues

Condition that may cause anaesthetic difficulty	e.g. Neuromuscular disease, Scoliosis	A
Previous failure or complication of anaesthesia	e.g. difficult intubation, failed epidural,	A

3.7. Procedures in the Index Pregnancy

Induction of labour		G/O
Instrumental vaginal delivery		G/O
Caesarean section		G/O
Manual removal		G/O

3.8. Neonatal Complications

Fetal Abnormality		
ANY significant abnormality detected on clinical examination or antenatal ultrasound		G/O
Poor Condition at Birth or in the First Hours of Life		
- Apgar < 7 at 5 minutes of age or < 2 minutes to establish respiration		G/O
- Persistent or recurrent cyanosis		G/O
- Lethargy, hypotonia,		G/O
- Convulsions or unresponsiveness		G/O
- Excessive Irritability		G/O
Growth and Feeding		
- Poor suck or feeding not related to gestation		G/O
- Dehydration or > 10% weight loss since birth		G/O
- Persistent vomiting without blood or bile		G/O
- Intra-uterine growth restriction		G/O
- Preterm birth	< 37 weeks'	
- Low birth weight	< 2500g	G/O
- Macrosomia	> 4500g or > 90th centile for GA	G/O
- Poor weight gain	Birth weight not regained by 14 days	G/O

Postmaturity		G/O
Evidence of (or Risk Factors for) System Disturbance		
Gastrointestinal	Unable to pass a gastric tube in a mucousy baby	G/O
	Abdominal distension or mass	G/O
	Persistent or bile stained vomiting or fresh blood in stools	G/O
	No passage of meconium by 24 to 36 hours	G/O
	Inguinal hernia	G/O
Genitourinary	Failure to pass urine in any 24 to 36 hour period	G/O
Haematology	Evidence of a bleeding tendency: haematemesis, melena, haematuria, purpura, generalised petechiae	G/O
	Haemorrhage from cord or other site	G/O
	Maternal thrombocytopenia	G/O
	Maternal isoimmunisation	P
Infection	Risk factor for sepsis - membrane rupture > 24 hours	G/O
	Maternal chorio-amnionitis: fetal tachycardia, maternal pyrexia, offensive liquor	G/O
	Temp < 36.0 C or > 37.5 C confirmed within one hour following appropriate management	G/O
	Intrauterine infection e.g. toxoplasmosis, rubella, CMV, syphilis	G/O
Jaundice	Any in first 24 hours	P
	Bilirubin > 250 micromol/l in first 48 hours	P
	Bilirubin > 300 micromol/l at any time	P
	Late jaundice: visible or > 150 micromol/l from 2 weeks in term infant and 3 weeks in preterm	G/O

	infant.	
	Significant jaundice in previous infant	G/O
Chemical Dependency	E.g. methadone, marijuana, alcohol, codeine, valium	G/O
Endocrine	Infant of diabetic mother	G/O
	Infant of mother with significant thyroid disease	G/O
Genetic - Family history with risk factors for baby	e.g. vesico-ureteric reflux, congenital heart disease, deafness	G/O
Orthopaedic	Unstable hips, breech delivery, family history of dislocated hips	G/O
	Talipes equinovarus or significant positional foot deformity	G/O
Respiratory	Any, persistent grunting, pallor	G/O
- RDS (any of the following features: cyanosis, RR>60, nasal flaring, persistent grunting, intercostal retraction)		G/O
- Apnoea		G/O
- Stridor, nasal obstruction		G/O
Previous Adverse Perinatal Outcome	Maternal request or anxiety regarding normality	G/O
Maternal medication - with risk to baby	e.g. carbimazole, antipsychotics, antidepressants, anticonvulsants	G/O

National Midwifery Guidelines for Consultation and Referral

Australian College of Midwives

2nd Edition

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DISCLAIMER

These guidelines are intended to provide information enabling the midwife to integrate evidence with experience (clinical judgment) in providing midwifery care; and to assist midwives in their discussions with women. The guidelines are not designed to be prescriptive.

The Guidelines should in no way be interpreted and/or be used as a substitute for an individual midwife's decision making and judgment in situations where care has been negotiated within the context of informed decision making by the individual woman.

Table Of Contents

Guidelines Development

Consultation

This is the second edition of the *National Midwifery Guidelines for Consultation and Referral* published by the Australian College of Midwives. The 2004 edition of these *Guidelines* has been revised and updated on behalf of the Australian College of Midwives by a multidisciplinary Expert Working Group.

The *Guidelines* were revised following national consultation with organisations and individuals from a wide range of stakeholder professions, organisations and consumers. In March 2007, interested parties across Australia were formally invited to submit comments and any recommendations for amendment, together with supporting evidence, regarding the 2004 edition of the *Guidelines*. Calls for submissions were also distributed in the ACM's national news magazine, on the ACM's website and in e-bulletins. Interested organisations were also invited to nominate a representative to participate in a Reference Group.

Submissions received were reviewed by a multidisciplinary Expert Working Group comprising midwives, medical practitioners, managers and consumers from across Australia. The Expert Working Group met in June 2007 to identify consensus changes to the *Guidelines* to ensure they continue to reflect contemporary research evidence, are clearly communicated, and remain relevant to the provision of maternity care in Australia. The revised draft of the *Guidelines* was ready for further consultation by December that year.

In April 2008, the revised version of the *Guidelines* was circulated to members of the Reference Group, comprised of representatives of organisations identified as having a stakeholder interest in the provision of maternity care by midwives. Members of the Reference Group did not meet as a group but were invited to submit initial comments or recommendations on the first edition of the revised *Guidelines* in April 2007 and then to review amendments made to the revised edition before re-publication in 2008. Unfortunately, some identified stakeholder organisations declined to be represented on the Reference Group.

The Expert Working group considered further feedback before finalising the document ready for re-publication, once approved by the ACM Board of Directors.

Acknowledgements

The Australian College of Midwives would like to thank all those individuals and organisations who have given their time and expertise in contributing to these *Guidelines* and their revision.

In particular, the College acknowledges and thanks Professor Sally Tracy, Chair of the Expert Working Group and all other members of the group, who gave generously of their time and expertise on a voluntary basis. These revised *Guidelines* would not have been possible without the serious and considered input provided by the Expert Working Group. Members of this group contributed as individual volunteers, not as representatives of their employers.

The Expert Working Group comprised the following individuals:

Professor Sally Tracy (Chair)	Professor of Women's Health Nursing & Midwifery, Royal Hospital for Women and UTS, Sydney, NSW
Dr Andrew Bisits,	Consultant Obstetrician, Hunter New England Area Health Service, NSW
Professor Pat Brodie	President, Australian College of Midwives
Justine Caines	Consumer representative, Maternity Coalition
Shea Caplice	Clinical Midwifery Consultant, RHW, Sydney
Helen Cooke	Clinical Midwifery Consultant, Sydney West Area Health Service, Sydney
Roslyn Donellan - Fernandez	Midwifery Unit Head, Midwifery Group Practices, Women's and Children's Hospital, Adelaide, SA
Michelle Erofeyeff	Consumer representative , Mums@Ryde NSW
Jane Grant	Caseload Midwife, Ryde Midwifery Group Practice, NSW
Gill Hall	Senior Midwife, Canberra Midwifery Program, Canberra, ACT
Donna Hartz	Clinical Midwifery Consultant, Sydney South West Area Health Service NSW
Carolyn Hastie	Senior Midwife, Belmont Birthing Service, Newcastle, NSW
Marie Heath	Midwife in Private Practice, rural NSW.
Sue Hendy	Clinical Midwifery Consultant, Aboriginal Maternal and Infant Health Strategy, NSW
Leonie Hewitt	Caseload Midwife, Ryde Midwifery Group Practice, NSW
Patrice Hickey	Clinical Midwife Consultant, Sunshine Hospital, Western Health, VIC
Anne Keely	Caseload Midwife, Ryde Midwifery Group Practice, NSW

Professor Marc Keirse	Professor of Obstetrics & Gynaecology, Flinders University, SA
A/Prof Sue Kildea	Associate Professor in Midwifery, Charles Darwin University, Darwin, NT
Anne Lainchbury	Clinical Midwifery Consultant, Royal Hospital for Women, Randwick, NSW
Paula Laws	Senior Data Analyst, AIHW National Perinatal Statistics Unit, UNSW, Sydney
Professor Nicky Leap	Professor of Midwifery Practice Development and Research, South Eastern Sydney and Illawarra Area Health Service, NSW
Kathren Lingard	Clinical Midwifery Consultant, RNS and Ryde Hospitals, Sydney, NSW
Yvonne McCann	Director, Clinical Services, Women's and Children's Health, RNS, Sydney, NSW
Dr Michael Nicholl	Director of Obstetrics, Royal North Shore Hospital, Northern Sydney and Central Coast Area Health Service, NSW
Dr Anne Nixon	Midwifery Unit Head, Midwifery Group Practices, Women's and Children's Hospital, Adelaide, SA
Bruce Teakle	Consumer representative, Maternity Coalition
Jocelyn Toohill	Queensland representative, ACM, Queensland
Dr Mark Tracy	Consultant Neonatologist, Sydney West Area Health Service, NSW
Professor William Walters	Executive Clinical Director, Royal Hospital for Women, Randwick, NSW
Liz Wilkes	Professional Officer, Australian College of Midwives

Thanks also to Therese Lahoud for taking minutes.

1. Preamble

In early 2007, the Australian College of Midwives (ACM) commissioned the revision of the *National Midwifery Guidelines for Consultation and Referral (*the *Guidelines)*. First published in 2004, the *Guidelines* have been developed based on comparable guidelines in use in other OECD countries [1,2,3,4] as well as on a thorough review of current evidence based practice in maternity care.

In the first edition of the *Guidelines*, the College made clear its commitment to reviewing and updating them once they had been in widespread use to ensure they were clear, comprehensive and usable. Regular revision ensures that the *Guidelines* continue to reflect the latest available research evidence on best practice.

After three years of widespread use by maternity services across Australia, the first revision of these *Guidelines* commenced in 2007. The ACM established a multidisciplinary Expert Working Group and called for submissions from a wide range of experts—including midwives, doctors, health service managers, regulators, employers and consumers—on the evidence base, clarity and usefulness of the 2004 *Guidelines*. It also invited numerous stakeholder organisations to contribute to a Reference Group to review the recommendations of the Expert Working Group and ensure broad input into its deliberations.

When the Australian College of Midwives first published these *Guidelines*, it did so in an environment in which there was a lack of comprehensive guidelines to provide an evidence-based framework for collaboration between midwives and doctors in the care of individual women. In particular there was no single, nationally consistent and evidence based tool to assist midwives to make decisions about when to discuss care with other midwives, and/or to consult with or transfer a woman's care to a suitably qualified doctor. This was identified as a barrier to the successful establishment of midwifery services where midwives are primary care givers, offering women continuity of care in collaboration with other healthcare providers. These *Guidelines* were first developed to address this gap and the revised edition continues to meet the same need.

However, the *Guidelines* are relevant not only to services and individuals offering midwifery continuity of care. The *Guidelines* are intended to help all maternity services to meet national policy priorities aimed at improving the quality and safety of health care. When the Australian Council for Safety

and Quality in Health Care launched its National Action Plan in 2001, its then Chair, Professor Bruce Barraclough, argued that improving the safety and quality of patient care is one of the most important challenges facing health professionals: "…We must stop blaming individuals and put much greater effort into making our systems of care safer and better".[5] In 2006, the Council became the Australian Commission on Safety and Quality in Health Care. One of its key priorities is to support the development of nationally agreed standards that promote safer, more effective and more responsive care for consumers.

These *Guidelines* are intended to address this imperative by providing evidence based, national guidelines for midwives that are responsive to the identified needs and wishes of individual women and their families. Since their publication in 2004, the *Guidelines* have been well received. They are now in use in most maternity services across Australia. The adoption of this 2nd Edition of the *Guidelines* by all institutions and midwives who offer pregnant women midwifery care will help to ensure maternity services provide high quality, safe and collaborative care to women and their babies.

1. *Obstetrical Manual* . Final Report of The Obstetric Working Group of the National Health Insurance Board of the Netherlands.1998 http://europe.obgyn.net/nederl and/richtlijnen/vademecum_eng.htm
2. NZ Ministry of Health Maternity Services. *Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*. July 2002
3. College of Midwives of Ontario, 2000. *Indications for Mandatory Discussion, Consultation and Transfer of Care*. 2000
4. Booking and Transfer Criteria, Obstetric Service Ryde. June 2003
5. Australian Council for Safety and Quality in Health Care 2000.National Action Plan 2001

2. Guidelines Aims

The aim of the *National Midwifery Guidelines for Consultation and Referral* is to provide individual midwives with an evidence informed national framework for consultation and referral of care between midwives, doctors and other health care providers in consultation with the woman receiving care.

The *Guidelines* have been organised in a structured framework to inform decision-making by midwives on the care and advice provided to women and appropriate consultation and referral:

- at booking
- during pregnancy and the antenatal period
- during labour and birth
- during the postnatal period

3. Introduction

The Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral (the Guidelines)* have been developed to assist midwives responsible for providing care to a woman to decide when it is appropriate to discuss care of that woman with a medical or midwifery colleague, or to refer a woman for further care and/or advice.

The aim of the *Guidelines* is to promote a system of care based upon the principle of close mutual co-operation between primary, secondary or tertiary level maternity caregivers and the woman involved[1].

> *Primary maternity care* is where the responsibility for maternity care rests with the primary level maternity care provider, in this case, the midwife.
>
> *Secondary maternity care* is where the responsibility for maternity care rests with the medical practitioner such as a general practitioner, specialist obstetrician, or the medical staff on duty in the referral hospital.
>
> *Tertiary maternity care* is when responsibility for maternity care rests with a team of providers in a specialised hospital. This may include an obstetrician, neonatologist, midwife or other specialised services.

Midwives, as primary carers, need to make decisions when a woman in their care may need medical attention during pregnancy, labour, birth or the post-natal period. These *Guidelines* have been developed to provide midwives with support in doing this in consultation with the woman to whom the midwife is providing care. It is the intention that the *Guidelines* be used to facilitate consultation and integration of care between midwives and doctors, thereby giving confidence to providers, women and their families.

[1] The distinction between primary, secondary and tertiary level maternity caregivers should be seen as distinct from the levels of hospital grading currently under revision in Australia.

3.1 BASIC ASSUMPTIONS FOR MIDWIFERY CARE:

These *Guidelines* have been developed around the following set of core assumptions that are informed by international standards and best practice in maternity care.

1. Pregnancy, birth and the postnatal period are normal physiological processes.
2. Maternity care must be based on awareness of physical, emotional, social and cultural aspects of wellbeing for both the woman and her infant(s).
3. The achievement of collaboration and co-operation between the professional groups involved in maternity care is of major importance for optimal[2] care. This involves recognition of the particular expertise found within the various groups of health care-providers.
4. The woman and the midwife work together during the whole maternity experience, building a relationship of trust with each other, sharing information and decision making and recognising the active role that both play in the woman's maternity care.
5. Where a woman has selected a midwife for her care, the referral to secondary or tertiary level maternity care is carried out by the midwife (primary level caregiver), who is qualified for this task.
6. Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care or support to the woman.
7. In order to ensure that selection and referral take place appropriately, the expertise of the secondary and/or tertiary level health care-providers must be accessible to the midwife by means of consultation and advice.

[2] Optimal here means the best possible processes of care and outcomes for women and their babies, given their individual set of circumstances. See: Weigers, T.A., Keirse, M.J.N.C.,Berghs, G.A.H., van der Zee, J. (1996). An approach to measuring quality of midwifery care. *Journal of Clinical Epidemiology*: 49: 319-325.
Cragin, L.,Powell Kennedy, H. (2006) Linking obstetric and midwifery practice with optimal outcomes. *Journal of Obstetric Gynecologic and Neonatal Nursing*. 35(6) 779-785

3.2 GUIDING PRINCIPLES:

Use of the *Guidelines:*

1. As a primary caregiver, the midwife is responsible for her professional decision-making. These *Guidelines* are for the use of the midwife in making decisions.
2. If problems occur during pregnancy or birth, the midwife may consult with her peers in the first instance; or consult directly with a secondary or tertiary level health care provider and refer when appropriate.
3. The midwife discusses care of a woman, consults, or refers primary care responsibility according to the *Guidelines*.
4. The secondary or tertiary level health care-provider may also refer the woman back to primary care by the midwife at any time if the condition that prompted referral is no longer a risk factor.
5. The severity of the condition will influence these decisions.

Informed Choice

1. At booking, the midwife should outline the scope and boundaries of midwifery care. This will include an explanation of these Guidelines with the woman.
2. Midwifery care must be provided within the principle of informed choice. The midwife must provide the woman with sufficient information to inform the woman's consent to any procedure or advice. The woman has the right to give or refuse consent to any procedure or advice.
3. When a woman's choice is significantly at variance from professional advice or guidelines, the woman's decision and the information provided by the midwife should be carefully documented. In these circumstances Appendix A: "*When a woman chooses care outside the recommendations of the ACM Guidelines*"[3] provides guidance to the midwife, and a standardised consent form.[4]

[3] College of Midwives of Ontario When A Client Chooses Care Outside Midwifery Standards of Practice January 1994, Revised September 22, 2004

[4] This Midwifery/Multi Disciplinary Care Plan was developed by the Government of South Australia and was considered by the Expert Working Group as a negotiation tool. The document demonstrates a three way sign off by the midwife, the women and other health provider if involved. The tool defines the terms of engagement and helps providers acknowledge that women have choice. This tool is a negotiated care pathway which gives fully informed participation in decision making to the woman.

3.3 STRUCTURE OF THESE GUIDELINES

To optimise the quality and efficiency of the care provided, the Guidelines provide indicators to identify situations where midwives carry out risk-assessment and referral decisions. For the convenience of the practitioner, the *Guidelines* are organised into four main sections:

- Indications At Booking
- Indications Developed or Discovered During Pregnancy
- Indications During Labour and Birth
- Indications During the Postnatal Period

Each section contains ready-reference tables listing specific conditions or circumstances that a woman or her baby may present with, and includes the recommended response by the midwife in making a decision about appropriate care.

4. The Three Levels of Consultation and Referral

When a variance from normal arises during a woman's care, it is recommended the midwife undertake one or more of three steps:

A. Discuss the situation with a colleague - midwife, and/or with a medical colleague or other health care provider

B. Consult with a medical or other health care provider

C. Refer a woman or her infant to Secondary or Tertiary care.

4.1 DISCUSS

A: Discuss the situation with a colleague - midwife and/or with a medical colleague or other health care provider

4.1.1. It is the midwife's responsibility to initiate a discussion with, or provide information to, another midwife or health care provider, in order to plan and provide optimal care.

4.1.2. The midwife may recommend to the woman (or parents in the case of the baby) that consultation with another health care provider or medical practitioner is warranted, given that her pregnancy, labour, birth or postnatal time (or the baby) may be affected by the condition or situation.

4.1.3. Areas of discussion and involvement must be agreed upon and clearly documented.

4.2 CONSULT

B: Consult with a medical or other health care provider.

4.2. 1 A consultation refers to the situation where a midwife recommends the woman consult a medical practitioner, or where the woman requests another opinion of a health care provider.

4.2. 3. It is the midwife's responsibility to initiate a consultation and to clearly communicate to the health care provider that she is seeking a consultation.

4.2. 4. The consultation involves addressing the variance from normal* e.g., a 'face to face' assessment, the prompt communication of the findings and recommendations to the woman and the health care provider to whom referral is made.

4.2. 5. Where a consultation occurs, the decision regarding ongoing clinical roles/ responsibilities must involve a three-way discussion between the health care provider, the midwife and the woman concerned. This should include discussion about any need for, and timing of, medical practitioner review.

4.2. 6. The midwife or health care provider will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes and needs of the individual woman.

4.2. 7. After consultation with a medical practitioner, it should be clear whether primary care and responsibility:

a) continues with the midwife, or

b) is transferred to the medical practitioner.

4.2. 8. The midwife maintains overall responsibility for midwifery care within her scope of practice in collaboration with the medical practitioner and remains responsible for this discrete area of the woman's care.

4.2. 9. Where urgency, distance, or adverse circumstances make a 'face to face' consultation impossible between a woman and a health care provider the midwife should seek advice by phone. The midwife should document this request for advice in her records, and discuss with the woman the advice received.

4.2. 10. Areas of discussion and involvement must be agreed upon and clearly documented.

4.3 REFER

C: Refer a woman or her infant to Secondary or Tertiary Care.

4.3.1. When primary care is referred, permanently or temporarily, from the midwife to a medical practitioner, that professional, in consultation with the woman and midwife, assumes full responsibility for subsequent decision-making.

4.3.2. When primary care is referred to a medical practitioner, the midwife may continue to provide midwifery care within her scope of practice, in collaboration with the medical practitioner.

4.3.3. Areas of discussion and involvement must be agreed upon and clearly documented.

Table 4.1 Summary of Codes used for the health care providers

Code	Description	Care provider
A Discuss	The responsibility for maternity care in the situation described is with the midwife.	Midwife [5]
B Consult	Evaluation involving both primary and secondary care needs. The individual situation of the woman will be evaluated and agreements will be made about the responsibility for maternity care.	Medical/ Health care practitioner and/ or midwife depending on agreements
C Refer	This is a situation requiring medical care at a secondary or tertiary level for as long as the situation exists.	Medical practitioner (Where appropriate the midwife continues to provide midwifery care or support)

[5] A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures.

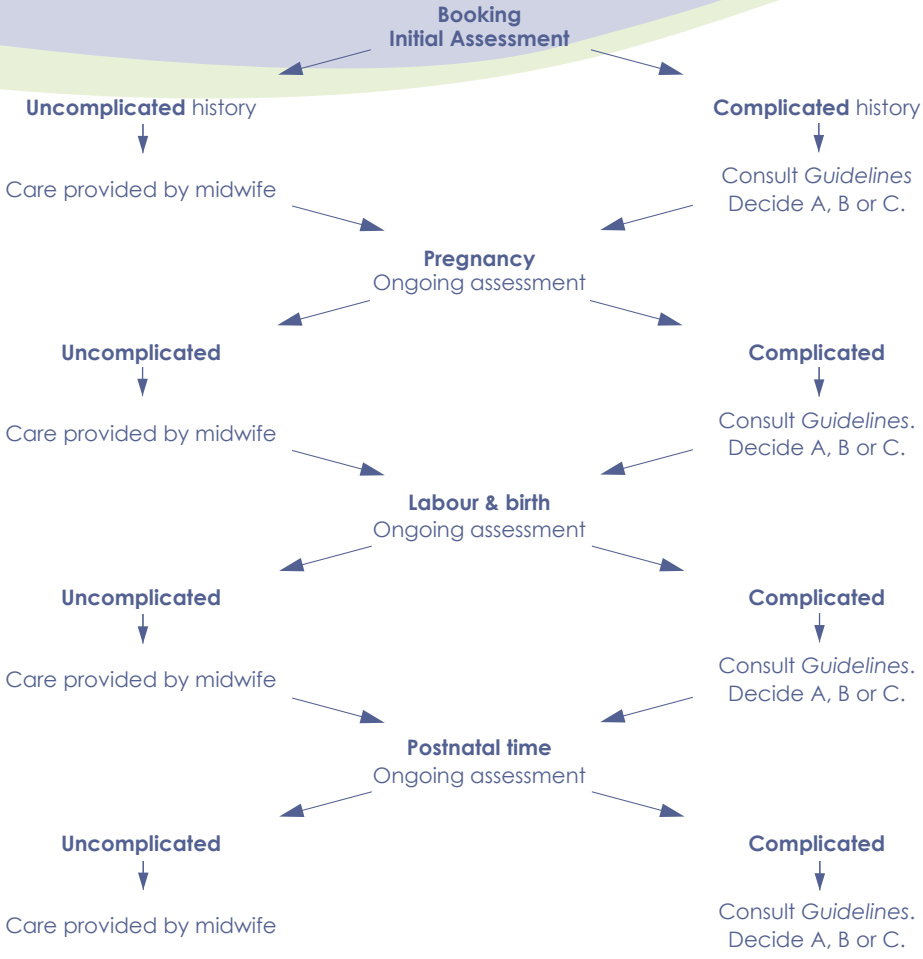
The midwife has an important task in health counseling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

Adopted 19th July 2005 ICM Congress, Brisbane, Australia.
Supersedes the ICM International Definition of the Midwife 1972 and its amendments of 1990.

5. How to use these Guidelines

Figure 1. A decision diagram for use by Midwives in daily practice



A Discuss with midwife/medical practitioner and care provided by midwife

B Consultation with medical practitioner and care continues with midwife or is transferred to medical practitioner

C Transfer care to medical practitioner

When there is any doubt, consultation is recommended.

Sources Adapted from: *Obstetrical Manual.* Final Report of the Obstetric Working Group of the National Health Insurance Board of the Netherlands. 2000; College of Midwives of Ontario, 2000. *Indications for Mandatory Discussion, Consultation and Transfer of Care* 2000; NZ Ministry of Health Maternity Services. *Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*. July 2002.

6. Indications at Booking

The following are specific indications for discussion, consultation and/or referral of care **when first discussing a woman's needs during a booking visit**. The main purpose of the indication list is to provide a guide for risk-selection.

The Codes in the Tables for A 'Discussion', B 'Consultation' and C 'Referral of Care' are explained in Part 4 of these *Guidelines*.

6.1. Medical Conditions

6.1.1	**Anaesthetic difficulties** · Previous failure or complication (e.g. difficult intubation, failed epidural) · Malignant hyperthermia or neuromuscular disease	 B C
6.1.2	**Autoimmune disease**	B
6.1.3	**Cardiovascular disease / Hypertension**	C
6.1.4	**Drug dependence or misuse** · Use of alcohol and other drugs · Medicine use: the effect of drugs on the pregnant woman and the unborn child, lactation and/or neonate. Information is available from – Mothersafe 1800 647 848	 B B
6.1.5	**Endocrine** Diabetes mellitus · Pre-existing insulin dependent or non insulin dependent · Gestational diabetes requiring insulin Thyroid disease · Hypothyroidism · Hyperthyroidism Addison's Disease; Cushing's Disease or other endocrine disorder requiring treatment	 C C B B C
6.1.6	**Gastro-intestinal** · Hepatitis B with positive serology (Hbs-AG+) · Hepatitis C · Inflammatory Bowel Disease This includes ulcerative colitis and Crohn's disease.	 B B B

... at booking

6.1.7	**Genetic – any condition**	B
6.1.8	**Haematological** · Thrombo-embolic process . Of importance is the underlying pathology and the presence of a positive family medical history · Coagulation disorders · Anaemia at booking irrespective of how treated or whether it responds to treatment Anaemia defined as Hgb < 9g/dL	C C B
6.1.9	**Infectious Diseases** · HIV-infection · Rubella · Cytomegalovirus · Parvo virus infection · Varicella/Zoster virus infection · Herpes genitalis: primary infection · Herpes genitalis: recurrent infection · Tuberculosis: active tuberculous or a history of Tuberculosis · Syphilis o Positive serology and treated o Positive serology and not yet treated o Primary infection · Toxoplasmosis If there is a history of viral ,microbial,or parasitic infections whether active or a previous medical history then medical consultation is required.	C B B B B A A B B B B B
6.10	**Maternal Age (under 14 and older than 45 years)**	A/B
6.11	**Maternal Weight > 100kg or Body Mass Index <17 and >35**	B
6.1.12	**Neurological** · Epilepsy, without medication or in the past without treatment and no seizures in the last 12 months · Epilepsy, with medication or seizure in the last 12 months · Subarachnoid haemorrhage, aneurysms · Multiple sclerosis · AV malformations · Myasthenia gravis · Spinal cord lesion (para or quadraplegia) · Muscular dystrophy or Myotonic Dystrophy	B B/C C B C C C C
6.1.13	**History of Mental Health Disorders** · Care during pregnancy and birth will depend on the severity and extent of the mental health disorder.	B

6.1.14	**Renal function disorders** · Disorder in renal function, with or without dialysis · Urinary tract infections · Pyelitis	 C B B
6.1.15	**Respiratory Disease** · Asthma Mild · Asthma Moderate (i.e. oral steroids in the last year and maintenance therapy) · Severe Lung function disorder	 B C C
6.1.16	**System/connective tissue diseases** · These include rare maternal disorders such as systemic lupus erythematosus (SLE), anti-phospholipid syndrome (APS), scleroderma, rheumatoid arthritis, periarteritis nodosa, Marfan's syndrome, Raynaud's disease and other systemic and rare disorders.	**C**

6.2. Pre-existing gynaecological disorders

6.2.1	**Pelvic floor reconstruction** · This refers to colpo-suspension following prolapse, fistula and/or previous rupture.	B
6.2.2	**Cervical Abnormalities** · Cervical amputation · Cervical cone biopsy · Cervical surgery with or without subsequent vaginal birth · Abnormalities in cervix cytology (diagnostics, follow-up)	 C B A/B A/B
6.2.3	**Uterine Abnormalities** · Myomectomy /hysterotomy · Bicornuate uterus	 B B/C
6.2.4	**Intra Uterine Contraceptive Device (IUCD) in situ**	B
6.2.5	**Infertility treatment**	B
6.2.6	**Pelvic deformities (trauma, symphysis rupture, rachitis)**	B
6.2.7	**Female Genital Circumcision**	B

... at booking

6.3 Previous Obstetric history

6.3.1	**Active blood group incompatibility** (Rh, Kell, Duffy, Kidd)	C
6.3.2	**ABO-incompatibility**	B
6.3.3	**Hypertension in the previous pregnancy**	A/B
6.3.4	**Pre-eclampsia in the previous pregnancy**	B
6.3.5	**Eclampsia**	C
6.3.6	**Recurrent miscarriage** (3 or more times)	A/B
6.3.7	**Pre-term birth (<37 weeks) in a previous pregnancy**	A/B
6.3.8	**Cervical incompetence** (and/or Shirodkar-procedure)	C
6.3.9	**Placental abruption**	B
6.3.10	**Forceps or vacuum extraction**	A/B
6.3.11	**Caesarean section**	B
6.3.12	**Fetal growth disturbance**	B
6.3.13	**Asphyxia (defined as an APGAR score of <7 at 5 minutes)**	B
6.3.14	**Perinatal death**	B
6.3.15	**Child with congenital and/or hereditary disorder**	B
6.3.16	**Postpartum haemorrhage as a result of** • episiotomy • cervical tear • other causes (>1000 ml)	A C B
6.3.17	**Manual removal of placenta**	A
6.3.18	**Placenta accreta**	C
6.3.19	**3rd or 4th degree perineal laceration** · functional recovery · no/poor function recovery	 B B
6.3.20	**Symphysis pubis dysfunction**	A/C
6.3.21	**Postpartum depression**	A/B
6.3.22	**Postpartum psychosis**	C
6.3.23	**Grand multiparity** – defined as parity >5.	A/B
6.3.24	**Shoulder Dystocia**	B

7. Indications Developed/Discovered During Pregnancy

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are **identified during pregnancy.** The main purpose of the indication list is to provide a guide for risk-selection.

The Codes in the Tables for A Discussion, B Consultation and C Referral of Care are explained in Part 4 of these *Guidelines*.

7.1.1	**Uncertain duration of pregnancy by amenorrhoea >20 weeks** · Consultation is required when the duration of pregnancy is uncertain after 20 weeks amenorrhoea. The primary care provider has access to sufficient additional diagnostic tools in the first 20 weeks.	B
7.1.2	**Laparotomy during pregnancy**	C
7.1.3	**Cervix cytology** · CIN III or higher · CIN 1 & 2	 C B
7.1.4	**Mental Health disorders** (neuroses/psychoses)	B
7.1.5	**Hyperemesis gravidarum** · Referral to secondary care is necessary for treatment of this condition. After recovery the pregnancy and birth can take place at primary care level.	B
7.1.6	**Ectopic pregnancy**	C
7.1.7	**Antenatal screening** · Attention should be given to the presence of risk factors for congenital abnormalities. If no abnormalities can be found, then further care may take place at a primary level.	A/C
7.1.8	**(Suspected) fetal abnormalities**	A/C
7.1.9	**Pre-term rupture of membranes** (<37 weeks amenorrhea)	C
7.1.10	**Gestational Hypertension (GH) (>20 weeks gestation):** · average SBP > 140mmHg and/or DBP >90 mmHg (after overnight rest, or after completion of a day assessment visit), without any evidence of multisystem dysfunction. GH resolves within 3 months postpartum.	B
7.1.11	**Preeclampsia (PE):** · Development of SBP > 140mmHg and/or DBP >90 mmHg Preeclampsia usually occurs after 20 weeks gestation in women with no previous history of hypertension, cardiac or renal, plus evidence of other organ involvement (eg proteinuria, renal insufficiency, liver disease, neurological problems, haematological disturbances, fetal growth restriction.) PE resolves within 3 months postpartum.	C
7.1.12	**Eclampsia**	C

...during pregnancy

7.1.13	**Chronic Hypertension:** · Hypertension that is present in the pre-conception period or the first half of pregnancy. It may be essential where there is no apparent cause or secondary where the hypertension is associated with renal, renovascular, endocrine disorder or aortic coarctation. Diastolic pressure should be recorded as Point V Korotkoff (K5) (i.e. the point of disappearance of sounds)	C
7.1.14	**Blood group incompatibility**	C
7.1.15	**Coagulation disorders**	B
7.1.16	**Recurring vaginal blood loss prior to 16 weeks**	A/B
7.1.17	**Vaginal blood loss at or after 16 weeks**	B
7.1.18	**Placental abruption**	C
7.1.19	**Size/date discrepancy:** Small for dates. Large for dates. (Definition: symphysis fundal height >3cm or <3cm from gestational age)	B
7.1.20	**Post-term pregnancy** (This refers to amenorrhoea lasting longer than 42 completed weeks or 294 days.)	B
7.1.21	**Threat of, or actual, pre-term birth.**	B
7.1.22	**Incompetent cervix**	C
7.1.23	**Symphysis pubis dysfunction** (pelvic instability)	A
7.1.24	**Multiple pregnancy**	C
7.1.25	**Non cephalic presentation at full term** Breech presentation (refer for ECV at 35 weeks)	C C
7.1.26	**Failure of head to engage at full term** · If at full term there is a suspected cephalo-pelvic disproportion, placenta praevia or comparable pathology, consultation is indicated.	B
7.1.27	**No prior prenatal care** (± full term)	B
7.1.28	**Baby for adoption.**	B
7.1.29	**Fetal death in utero.**	C
7.1.30	**Fibroids**	B

...during pregnancy

7.1.31	**Endocrine**	
	· Diabetes mellitus	
	o Gestational diabetes requiring insulin	C
	· Thyroid disease	
	o Hypothyroidism	B
	o Hyperthyroidism	B
	· Addison's Disease; Cushing's Disease or other endocrine disorder requiring treatment.	C
7.1.32	**Gastroenterology**	
	· Hepatitis B with positive serology (Hbs-AG+)	B
	· Hepatitis C	B
	· Inflammatory Bowel Disease This includes ulcerative colitis and Crohn's disease.	B
7.1.33	**Hernia nuclei pulposi (slipped disc)**	B
7.1.34	Haematological	
	· Thrombosis	C
	· Coagulation disorders	C
	· Anaemia at booking or close to term	B
7.1.35	**Infectious Diseases**	
	· HIV-infection	C
	· Rubella	B
	· Toxoplasmosis	B
	· Cytomegalovirus	B
	· Parvo virus infection	B
	· Varicella/Zoster virus infection	C
	· Tuberculosis: an active tuberculous process	C
	· Herpes genitalis	
	o Primary infection	B
	o If late in pregnancy	C
	o Recurrent	A
	· Syphilis	
	o Positive serology and treated	A/B
	o Positive serology and not yet treated	/B
	o Primary infection	B
7.1.36	**Renal function disorders**	
	· Urinary tract infections	B
	· Pyelitis	C
7.1.37	**Respiratory Disease**	
	· Asthma	A/B

8. Indications During Labour and Birth

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are **identified during labour and birth.** The main purpose of the indication list is to provide a guide for risk-selection.
The Codes in the Tables for A 'Discussion', B 'Consultation' and C 'Referral of Care' are explained in Part 4 of these *Guidelines.*

8.1.1	**Gestational hypertension (GH)**	C
8.1.2	**Preterm labour < 37 weeks**	C
8.1.3	**Preterm pre-labour rupture of membranes (PROM) before 37weeks**	C
8.1.4	**Prolonged rupture of membranes (PROM) >18 hours**	B
8.1.5	**Abnormal presentation**	C
8.1.6	**Breech Presentation**	C
8.1.7	**Meconium stained liquor**	A/C
8.1.8	**Suspected placenta abruption and/or praevia**	C
8.1.9	**Pre-eclampsia**	C
8.1.10	**Pyrexia**	C
8.1.11	**Active genital herpes in late pregnancy or at onset of labour**	C
8.1.12	**Multiple pregnancy**	C
8.1.13	**Confirmed non-reassuring fetal heart patterns**	C
8.1.14	**Prolonged active phase**	B
8.1.15	**Prolonged second stage**	B
8.1.16	**Unengaged head in active labour in primipara**	B
8.1.17	**Prolapsed cord or cord presentation**	C
8.1.18	**Vasa praevia**	C
8.1.19	**Shoulder dystocia**	C
8.1.20	**Uterine rupture**	C
8.1.21	**Third or fourth degree perineal tear**	C
8.1.22	**Retained placenta**	B
8.1.23	**Uterine inversion**	C
8.1.24	**Post partum haemorrhage >1000mls**	C
8.1.25	**Fetal death during labour**	C
8.1.26	**Shock /Maternal Collapse**	C

9. Indications During Post-partum Period

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are identified in the mother or baby in the early weeks after the birth. The main purpose of the indication list is to provide a guide for risk-selection.

The Codes in the Tables for A Discussion, B Consultation and C Referral of Care are explained in Part 4 of these *Guidelines*.

9.1 Indications: Postpartum (Maternal)

9.1.1	**Suspected maternal infection** e.g. breast, abdomen, wound, uterine, urinary tract, perineum	B
9.1.2	**Temperature over 38C on more than one occasion**	B
9.1.3	**Persistent hypertension**	B
9.1.4	**Serious psychological disturbance**	B
9.1.5	**Haemorrhage > 1000mls**	C
9.1.6	**Postpartum eclampsia**	C
9.1.7	**Thrombophlebitis or thromboembolism**	C
9.1.8	**Uterine prolapse**	C
9.1.9	**Significant social isolation and lack of social support**	B

9.2 Indications: Postpartum (Infant)

9.2.1	**Apgar less than 7 at 5 minutes**	C
9.2.2	**< 37 weeks gestational age**	B
9.2.3	**Infant less than 2500 g**	B
9.2.4	**Less than 3 vessels in umbilical cord**	B
9.2.5	**Excessive moulding and cephalhaematoma**	B
9.2.6	**Abnormal findings on physical examination**	B
9.2.7	**Excessive bruising, abrasions, unusual pigmentation and/or lesions**	C
9.2.8	**Birth injury requiring investigation**	B
9.2.9	**Birth trauma**	B
9.2.10	**Congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia**	C
9.2.11	**Major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele**	C
9.2.12	**Abnormal heart rate or pattern**	B
9.2.13	**Abnormal cry**	B
9.2.14	**Persistent abnormal respiratory rate and/or pattern**	B

...during post-partum

9.2.15	**Persistent cyanosis or pallor**	B
9.2.16	**Jaundice in first 24 hours**	B
9.2.17	**Suspected pathological jaundice after 24 hours**	B
9.2.18	**Temperature instability**	C
9.2.19	**Temperature less than 36° C, unresponsive to therapy**	B
9.2.20	**Temperature more than 37.4° C, axillary, unresponsive to non-pharmaceutical therapy**	C
9.2.21	**Vomiting or diarrhoea**	C
9.2.22	**Infection of umbilical stump site**	B
9.2.23	**Feeding problems**	A/C
9.2.24	**Significant weight loss in the first week (usually more than 10% of body weight)** **Failure to regain birth weight in three weeks**	B B
9.2.25	**Failure to thrive**	B
9.2.26	**Failure to pass urine or meconium within 24 hours of birth**	A/B
9.2.27	**Failure to pass urine or meconium within 36 hours of birth**	B
9.2.28	**Suspected clinical dehydration**	B
9.2.29	**Suspected seizure activity**	C

10. Review of these Guidelines

It is the intention of the Australian College of Midwives to continue to update and republish these Guidelines at timely intervals. Organisations and individuals are invited to send any comments on these guidelines to:

Post: Australian College of Midwives
PO Box 87 Deakin West,
ACT 2600, Australia or

Email: executiveofficer@midwives.org.au

11. Bibliography

Albers LL. 2001. Monitoring the fetus in labor: evidence to support the methods. *J Midwifery Womens Health.* Nov-Dec; 46(6): 366-73. Review

Albers LL, Sedler KD, Bedrick EJ, Teaf D, Peralta P. 2006. Factors related to genital tract trauma in normal spontaneous vaginal births *Birth*. 33(2):94-100.

Althuisius SM, Dekker GA, Hummel P, et al. 2001. Final results of the Cervical Incompetence Prevention Randomised Cerclage Trial (CIPRACT): therapeutic cerclage with bed rest versus bed rest alone. *Am J ObstetGynecol*. 185:1106 –1112.

AMAP.2003. Barclay L, Brodie P, Lane K, Leap N, Reiger K, Tracy S (2003) *The Final Report of The Australian Midwifery Action Project, (AMAP)* Centre for Family Health and Midwifery, UTS, Sydney.

American Public Health Association, Inc. 2001. Supporting Access to Midwifery Services in the United States (Position Paper) *American Journal of Public Health.* 91(3): 482-485.

Anim-Somuah M, Smyth R, Howell C. 2005. Epidural versus non-epidural or no analgesia in labour. *Cochrane Database of Systematic Reviews* 2005, Issue 3. Art. No.: CD000331. DOI: 10.1002/14651858.CD000331.pub2 (accessed 28th August 2008)

Audit Commission. 1997. *First class delivery: improving maternity services in England and Wales.* London: Audit Commission Publications.

Australian Council for Safety and Quality in Health Care. 2000.*National Action Plan 2001.*

Bauer K, Cowett RM, Howard GM, et al. 1993. Effect of intrauterine growth retardation on postnatal weight change in preterm infants. *J Pediatr.* 123(2): 301-6.

Beckmann MM, Garrett AJ. 2006. Antenatal perineal massage for reducing perineal trauma. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005123. DOI: 10.1002/14651858.CD005123.pub2 (accessed 28th August 2008)

Benjamin Y, Walsh D, Taub N. 2001. A comparison of partnership caseload midwifery care with conventional team midwifery care: labour and birth outcomes. 2001. *Midwifery.* 17: 234-240.

Biro M, Waldenstrom U, Pannifex J H. 2000. Team Midwifery Care in a Tertiary Level Obstetric Service: A Randomized Controlled Trial. *Birth. Issues in Perinatal Care.* 27(3):168-173.

Blondel B, Breart G, Glado J, et al. 1990. Evaluation of the home-visiting system for women with threatened preterm labour. Results of a randomised controlled trial. *Eur J Obstet Gynaecol Reprod Biol.* 34: 47–58.

Boer K, Smit BJ, van Huis AM, et al. 1994. Substance use in pregnancy: do we care? *Acta Paediatr Suppl*. 404: 65-71.

Brown MA, de Swiet M. 1999. Classification of hypertension in pregnancy. *Best Practice & Research in Clinical Obstet.Gynaecol.* 13: 27-39.

Buckley S. 2007. *Gentle Birth, Gentle Mothering.* http://www.sarahjbuckley.com/ (accessed 29th August 2008)

Campbell R, MacFarlane A. 1994. 2nd ed. *Where to be Born? The Debate and the Evidence*. National Perinatal Epidemiology Unit, Oxford.

Carroli G, Belizan J. 1999. Episiotomy for vaginal birth. *Cochrane Database of Systematic Reviews* 1999, Issue 2. Art. No.: CD000081. DOI: 10.1002/14651858.CD000081 (accessed 28th August 2008)

Catalano PM. 2007. Management of obesity in pregnancy. *Obstet Gynecol*. 109(2 Pt 1): 419-33.

Chaillet N, Dumont A. 2007. Evidence-Based Strategies for Reducing Cesarean Section Rates: A Meta-Analysis *Birth*. 34 (1): 53-64

Chasnoff IJ, McGourty RF, Bailey GW, Hutchins E, Lightfoot SO, Pawson LL, Fahey C, May B, Brodie P, McCulley L, Campbell J. 2005. The 4P's Plus screen for substance use in pregnancy: clinical application and outcomes. *Journal of Perinatology*. 25: 368–374.

Cnattingius S, Forman MR, Berendes HW, et al. 1992. Delayed childbearing and risk of adverse perinatal outcome. A population-based study. *JAMA*. 268(7): 886-90.

College of Midwives of Ontario. 2000. *Indications for Mandatory Discussion, Consultation and Referral of Care*.

Cook RJ, Dickens BM, Fathalla MF. 2002. Female genital cutting (mutilation/circumcision): ethical and legal dimensions. *Int J Gynaecol Obstet*. 79: 281-7

Creasy RK. 1993. Preterm birth prevention : Where are we? *Am J Obstet Gynecol* .168: 1223–1230.

Creedy, DK, Shochet, IM, Horsfall J, 2000. Childbirth and the development of acute trauma symptoms: incidence and contributing factors. *Birth* 27: 104–111.

Crowther CA, Harding JE. 2007. Repeat doses of prenatal corticosteroids for women at risk of preterm birth for preventing neonatal respiratory disease. *Cochrane Database of Systematic Reviews* 2007, Issue 2. Art. No.: CD003935. DOI: 10.1002/14651858.CD003935.pub2 (accessed 28th August 2008)

Dahlen HG, Homer CS, Cooke M, Upton AM, Nunn R, Brodrick B. 2007. Perineal outcomes and maternal comfort related to the application of perineal warm packs in the second stage of labor: a randomised controlled trial. *Birth*. 34(4): 282-90.

Davey DA, MacGillivray I. 1988. The classification and definition of the hypertensive disorders of pregnancy. *Am J Obstet Gynecol*.158(4): 892-8.

Definitions, evaluation and classification of hypertensive disorders in pregnancy. 1997. *Canadian Medical Association Journal.* 157:715-25.

Department of Women's Health, Family and Community Health, World Health Organization. 2000. *A systematic review of the health complications of female genital mutilation including sequelae in childbirth* WHO/FCH/WMH/00.2, World Health Organization, Geneva.

Drugan A, Johnson MP, Reichler A, et al. 1996. Second-trimester minor ultrasound anomalies: impact on the risk of aneuploidy associated with advanced maternal age. *Obstet Gynecol*. 88(2): 203-6.

Earl-Slater A. 2002. *The Handbook of Clinical Trials and Other Research*. Radcliffe Medical Press: Abingdon UK.

Edge V, Laros RKJr. Pregnancy outcome in nulliparous women aged 35 or older. 1993. *Am J Obstet Gynecol.* 168(6 Pt 1): 1881-4.

Edwards, NP. (2005). Birthing Autonomy: Women's Experiences Of Planning Home Births: Routledge: Oxford.

Enkin M, Keirse MJNC, Neilson J, Crowther C, Duley L, Hodnett E, Hofmeyr J, *A Guide to Effective Care in Pregnancy and Childbirth.* 3rd Ed. OUP: Oxford. http://www.childbirthconnection.org (accessed 29th August 2008)

Flint C, Poulengeris P. 1989. The 'Know Your Midwife' scheme - a randomized trial of continuity of care by a team of midwives. *Midwifery*. 5:11-16

Fretts RC, Schmittdiel J, McLean FH, et al. 1995. Increased maternal age and the risk of fetal death. *N Engl J Med*. 333(15): 953-7

Gamble JA, Creedy DK, Moyle W, Webster J, McAllister M, Dickson P. 2007. Effectiveness of a counselling intervention after a traumatic childbirth: a randomized controlled trial. *Birth* 32(1): 11-19

Gamble JA, Creedy DK. 2001. Women's preference for a cesarean section: incidence and associated factors. *Birth*. 28: 101-110

Gordon B, Mackrodt C, Fern E, et al. 1998. The Ipswich Childbirth Study: 1. A randomised evaluation of two stage postpartum perineal repair leaving the skin unsutured. Br J Obstet Gynaecol. 105:435–440.

Gottvall K, Waldenstrom U. 2002. "Does a traumatic birth experience have an impact on future reproduction?" BJOG. 109:254-60

Graafmans WC, Richardus J-H, Macfarlane A, Rebagliato M, Blondel B, Verloove-Vanhorick SP, Mackenbach JP. 2003. Comparability of

published perinatal mortality rates in Western Europe: the quantitative impact of differences in gestational age and birthweight criteria. *Br J Obstet Gynaecol*. 108 (12): 1237- 1245.

Grant A, Gordon B, Mackrodt C, et al. 2001. The Ipswich childbirth study: one year follow up of alternative methods used in perineal repair. *Br J Obstet Gynaecol*. 108: 34–40.

Grant A, Penn ZJ, Steer PJ. 1996. Elective or selective caesarean delivery of the small baby? A systematic review of the controlled trials. *Br J Obstet Gynaecol.* 103:1197–1200.

Grimshaw JM, Russell IT, 1993. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet.* 342: 1317- 1322

Grol R, Grimshaw J. 2003. From best evidence to best practice: effective implementation of change in patients' care. *Lancet*. 362(9391):1225-30.

Guilliland K, Pairman S. 2001. *The Midwifery Partnership: A model for practice*. Department of Nursing and Midwifery Monograph Series 95/1. Victoria University of Wellington, NZ,

Gupta JK, Hofmeyr GJ, Smyth R. Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database of Systematic Reviews* 2003, Issue 2. Art. No.: CD002006. DOI: 10.1002/14651858.CD002006.pub2 (accessed 28th August 2008)

Gyetvai K, Hannah ME, Hodnett ED, et al. 1999. Tocolytics for preterm labor: A systematic review. *Obstet Gynecol*. 94: 869–877.

Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. 2000. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. *Lancet*. 356: 1375–1383.

Hansen SL, Clark SL, Foster JC. 2002. Active pushing versus passive fetal descent in the second stage of labor: a randomized controlled trial. *Obstet Gynecol*. 99: 29–34.

Harvey S, Jarrell J, Brant R, et al. 1996. A randomized controlled trial of nurse midwifery care. *Birth*. 23(3): 128-135

Henderson J, McCandlish R, Kumiega L, Petrou S. 2001. Systematic review of economic aspects of alternative models of delivery. *BJOG*. 108 (2):149-57

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. 2007. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 2007, Issue 2. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766. pub2 (accessed 28th August 2008)

Hodnett ED, Downe S, Edwards N, Walsh D. 2004. Home-like versus conventional institutional settings for birth. *Cochrane Database of Systematic Reviews* 2004, Issue 4. Art. No.: CD000012. DOI: 10.1002/14651858.CD000012.pub2 (accessed 28th August 2008)

Hodnett ED, Fredericks S. 2003. Support during pregnancy for women at increased risk of low birthweight babies. *Cochrane Database of Systematic Reviews* 2003, Issue 2. Art. No.: CD000198. DOI: 10.1002/14651858.CD000198 (accessed 28th August 2008)

Hofmeyr GJ, Kulier R. 1996. External cephalic version for breech presentation at term. *Cochrane Database of Systematic Reviews* 1996, Issue 2. Art. No.: CD000083. DOI: 10.1002/14651858.CD000083 (accessed 28th August 2008)

Hofmeyr GJ. 1998. Amnioinfusion for preterm rupture of membranes. *Cochrane Database of Systematic Reviews* 1998, Issue 1. Art. No.: CD000942. DOI: 10.1002/14651858.CD000942 (accessed 28th August 2008)

Hofmeyr GJ, Gyte G. 2008. Interventions to help external cephalic version for breech presentation at term. *Cochrane Database of Systematic Reviews* 2003, Issue 3. Art. No.: CD000184. DOI: 10.1002/14651858. CD000184.pub2 (accessed 28th August 2008)

Hofmeyer GJ, Duley L, Atallah A. 2007. Dietary calcium supplementation for prevention of pre-eclampsia and related problems: a systematic review and commentary. *BJOG*. 114(8):933-43.

Homer C, Brodie P, Leap N. 2008. *Midwifery Continuity of Care: A Practical Guide*. Sydney: Elsevier.

Homer C, Davis G, Brodie P, Sheehan A, Barclay L, Wills J, Chapman G. 2001. Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care. *BJOG*.108:16-22

Homer C, Matha D, Jordan L, Wills J, Davis G. 2001. Community-based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review*. 24(1): 85-93.

Hordnes K, Bergsjo P. Severe lacerations after childbirth. 1993. *Acta Obstet Gynecol Scand* .72(6): 413-22.

House of Commons Health Committee. 2003. Choice in Maternity Services. Ninth Report of Session 2002-2003. http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/796/796.pdf (accessed 29th August 2008)

Howell CJ, Chalmers I. 1992. A review of prospectively controlled comparisons of epidural with non-epidural forms of pain relief during labour. *Int J Obstet Anaesth*. 1: 93–110.

Hueston WJ, Rudy MA 1993. Comparison of labour and delivery management between nurse midwives and family physicians. *The J of Family Practice*. 37(5): 449-453

Isaacs JD, Magann EF, Martin RW, et al. 1994. Obstetric challenges of massive obesity complicating pregnancy. *J Perinatol*. 14(1): 10-4.

Johanson RB, Menon V. 1998. Vacuum extraction versus forceps for assisted

vaginal delivery. *Cochrane Database of Systematic Reviews* 1998, Issue 4. Art. No.: CD000224. DOI: 10.1002/14651858.CD000224 (accessed 28th August 2008)

Kalache A, Maguire A, Thompson SG. 1993. Age at last full-term pregnancy and risk of breast cancer. *Lancet*. 341(8836): 33-6.

Keirse MJNC, Rush RW, Anderson AB, et al. 1978. Risk of preterm delivery in patients with previous pre-term delivery and/or abortion. *Br J Obstet Gynaecol.* 85: 81–85.

Kenny, P. Brodie, P Eckermann,S. Hall, J. 1994. *Westmead Hospital Team Midwifery Project Evaluation. Final Report*. Westmead: Centre for Health Economics Research and Evaluation.

Kenyon S, Boulvain M, Neilson JP. 2004. Antibiotics for preterm rupture of membranes. *Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD001058. DOI:10.1002/14651858.CD001058 (accessed 28th August 2008)

Kenyon SL, Taylor DJ, Tarnow-Mordi W. 2001. Broad-spectrum antibiotics for preterm, prelabour rupture of fetal membranes: the ORACLE I randomised trial. *Lancet*. 357: 979–988.

Kenyon SL, Taylor DJ, Tarnow-Mordi W. 2001. Broad-spectrum antibiotics for spontaneous preterm labour: the ORACLE II randomised trial. *Lancet* 357: 989–994.

Kettle C, Johanson RB. Absorbable synthetic versus catgut suture material for perineal repair. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD000006. DOI: 10.1002/14651858.CD000006 (accessed 28th August 2008)

Kettle C, Hills RK, Jones P, Darby L, Gray R, Johanson R. 2002. Continuous versus interrupted perineal repair with standard or rapidly absorbed sutures after spontaneous vaginal birth: a randomised controlled trial. *Lancet*. 359(9325):2217-23

Kettle C, Hills RK, Ismail KMK. 2007. Continuous versus interrupted sutures for repair of episiotomy or second degree tears. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD000947. DOI: 10.1002/14651858.CD000947.pub2 (accessed 28th August 2008)

Kildea S. 1999. *And the women said…..reporting on birthing services for Aboriginal women from remote Top End Communities*. Women's Health Strategy Unit, Territory Health Services, Govt Print NT.

King J, Flenady V. 2002. Prophylactic antibiotics for inhibiting preterm labour with intact membranes. *Cochrane Database of Systematic Reviews* 2002, Issue 3. Art. No.: CD000246. DOI: 10.1002/14651858.CD000246 (accessed 28th August 2008)

King JF, Flenady VJ, Papatsonis DNM, Dekker GA, Carbonne B. 2002.

Calcium channel blockers for inhibiting preterm labour. *Cochrane Database of Systematic Reviews* 2002, Issue 3. Art. No.: CD002255. DOI: 10.1002/14651858.CD002255 (accessed 28th August 2008)

Kirkham M. 2003. *Birth Centres: A Social Model for Maternity Care*. London: Elsevier Science.

Kirkham M. 2000. *The Midwife /Mother Relationship*. London. Macmillan.

Kitzinger S. 1980. *Birth at Home*. Oxford: Oxford University Press.

Kitzinger S, Simkin P. 1984. *Episiotomy and the Second Stage of Labour* 2nd Ed. Seattle: Pennypress

Klein MC, Gauthier MD, Robbins JM, et al. 1994. Relationship of episiotomy to perineal trauma and morbidity, sexual function, and pelvic floor relaxation. *Am J Obstet Gynecol*. 17: 591–598.

Knuist M, Bonsel GJ, Zondervan HA, Treffers PE. 1998. Low sodium diet and pregnancy-induced hypertension: a multi-centre randomised controlled trial. *Br J Obstet Gynaecol.* 105(4):430-4.

Knuist M, Bonsel GJ, Zondervan HA, Treffers PE. 1998. Intensification of fetal and maternal surveillance in pregnant women with hypertensive disorders. *Int J Gynaecol Obstet*. 61(2): 127-33

Knuist M, Bonsel GJ, Zondervan HA, Treffers PE. 1998. Risk factors for preeclampsia in nulliparous women in distinct ethnic groups: a prospective cohort study. *Obstet Gynecol.* 92(2):174-8

Kristensen J, Vestergaard M, Wisborg K, Kesmodel U, Secher NJ. 2005. Pre-pregnancy weight and the risk of stillbirth and neonatal death BJOG: An International Journal of Obstetrics and Gynaecology 112 (4), 403–408.

Kumbi S, Isehak A. 1999. Obstetric outcome of teenage pregnancy in northwestern Ethiopia. *East Afr Med* J. 76:138–140.

Langer A, Villar J, Romero M, et al. 2002. Are women and providers satisfied with antenatal care? Views on a standard and a simplified, evidence-based model of care in four developing countries. *BMC Women's Health*. 2(1): 7. http:// www.ncbi.nim.nih.gov/pubmed/12133195 (accessed 29th August 2008)

Langer O, Langer N. 1993. Diabetes in women older than 40 years of age. Social and medical aspects. *Obstet Gynecol Clin North Am*. 20(2): 299-311.

Lansac J. 1995. Delayed parenting. Is delayed childbearing a good thing? *Hum Reprod.* 10(5): 1033-5.

Lauzon L, Hodnett E. 2001. Labour assessment programs to delay admission to labour wards. *Cochrane Database of Systematic Reviews* 2001, Issue 1. Art. No.: CD000936. DOI: 10.1002/14651858.CD000936 (accessed 28th August 2008)

Lauzon L, Hodnett ED. 2007. Antenatal education for self-diagnosis of the onset of active labour at term. *Cochrane Database of Systematic*

Reviews 2007, Issue 4. Art. No.: CD000935. DOI: 10.1002/14651858. CD000935 (accessed 28th August 2008)

Levine RU, Berkowitz KM. 1993. Conservative management and pregnancy outcome in diethylstilbestrol-exposed women with and without gross genital tract abnormalities. *Am J Obstet Gynecol.*169(5): 1125-9.

Lopez Bernal A. 2007. Overview. Preterm labour *BMC Pregnancy and Childbirth* 2007, 7(Suppl 1):S2

Luke B, Brown MB. : 2007. Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age. *Hum Reprod*. 22(5):1264-72

Lundquist M, Olsson A, Nissen E, et al. 2000. Is it necessary to suture all lacerations after a vaginal delivery? *Birth*. 27: 79–85.

MacDorman M, Singh G. 1998. Midwifery care, social and medical risk factors and birth outcomes in the USA. *Journal of Epidemiology & Community Health.* 52(5): 310-317.

MacGillivray I. Pre-eclamsia. *The hypertensive disease of pregnancy*. 1983. London: W.B. Saunders.

Mancuso A, D'Anna R, Leonardi R. Pregnancy in the obese patient. 1991. *Eur J Obstet Gynecol Reprod Biol*. 39(2): 83-6.

Marang-van de Mheen, PJ, Gunning-Schepers, Louise J. 1998. Variation between Studies in Reported Relative Risks Associated with Hypertension: Time Trends and Other Explanatory Variables. *American Journal of Public Health* 88(4): 618-622

McCandlish R, Bowler U, van Asten H, et al. 1998. A randomised controlled trial of care of the perineum during second stage of normal labour. *Br J Obstet Gynaecol.*105:1262–1272

McCourt C, Weaver J, Statham H, Beake S, Gamble J, Creedy D 2007. Elective cesarean section and decision making: a critical review of the literature. *Birth*. 34(1):65-79.

McCourt, C, Page, L. 1996. *Report on the Evaluation of One-to-One Midwifery Practice* Wolfson School of Health Sciences, Thames Valley University, London.

Moore ML, Meis PJ, Ernest JM, et al. 1998. A randomized trial of nurse intervention to reduce preterm and low birth weight births. *Obstet Gynecol.* 91:656–661.

Morrison JJ, Rennie JM. 1997. Clinical, scientific and ethical aspects of fetal and neonatal care at extremely preterm periods of gestation. *Br J Obstet Gynaecol.*104: 1341–1350.

NHMRC National Health & Medical Research Council 1996. *Options for Effective Care in Childbirth* Australian Government Printing Service, Canberra.

NICE 2008. *Antenatal care: Routine care for the healthy pregnant woman* National Institute for Clinical Excellence, London. http://www.nice.org.uk/pdf/ CG6 (accessed 29th August 2008)

NICE 2003 *Caesarean Section Guideline Evidence Tables second consultation.* National Institute for Clinical Excellence, London. http://www.nice.org.uk/nicemedia/pdf/CSguideline_Evidencetables_2ndconsultation_draft.pdf (accessed 29th August 2008)

NHMRC National Health & Medical Research Council. 1998. *Review of Services Offered by Midwives* Australian Government Printing Service, Canberra.

North Staffordshire Changing Childbirth Research Team. 2000. A randomised study of midwifery caseload care and traditional 'shared care'. *Midwifery*. 16(4): 295-302.

NSW Department of Health 1989. *Maternity Services in New South Wales. Final Report of the Ministerial Taskforce on Obstetric Services in New South Wales.* Sydney: Department of Health Publication No: (HSU) 89-007.

NSW Health. 2000. *NSW Framework for Maternity Services: providing structure and direction for the future development of maternity service.*

NZ Ministry of Health Maternity Services. 2002. *Notice Pursuant to Section 88 of the New Zealand Public health and Disability Act.*

Obstetric Manual. National Health Insurance Board of the Netherlands 1998, *Obstetric Manual: Final Report of the Obstetric Working Group of the Obstetric Working Group of the (abridged version)* Amstelveen.

O'Reilly Green C, Cohen WR. Pregnancy in women aged 40 and older. *Obstet Gynecol Clin North Am* 1993; 20(2): 313-31.

Ong KK, Ahmed ML, Emmett PM, Preece MA, Dunger DB. 2000. Association between postnatal catch-up growth and obesity in childhood: prospective cohort study. *BMJ*. 320(7240):967-71.

Ovelese Y, Scorza WE, Mastrlia r, Smulian JC. 2007. Postpartum hemorrhage. *Obstet Gynecol Clin North Am.* 34(3):421-41,

Page L, McCandlish R. 2006. *The New Midwifery: Science and Sensitivity in Practice* 2nd Edition. London: Churchill Livingstone.

Page L, McCourt C, Beake S, Hewison J. 1999. Clinical interventions and outcomes of 'one-to-one' midwifery practice. *J of Public Health Medicine*. 21(3): 243-248.

Palo P, Erkkola R. 1993. Risk factors and deliveries associated with preterm, severely small for gestational age fetuses. *Am J Perinatol.* 10(1): 88-91.

Peipert JF, Bracken MB. 1993. Maternal age: an independent risk factor for cesarean delivery. *Obstet Gynecol* .81(2): 200-5.

Phillips OP, Cromwell S, Rivas M, et al. 1995. Trisomy 21 and maternal age of

menopause: does reproductive age rather than chronological age influence risk of non disjunction? *Hum Genet.* 95(1): 117-8.

Prysak M, Lorenz RP, Kisly A. 1995. Pregnancy outcome in nulliparous women 35 years and older. *Obstet Gynecol*. 85(1): 65-70.

Ramsay LE, Williams B, Johnston GD, MacGregor GA, Poston L, Potter JF, Poulter NR, Russell, G. 1999. British Hypertension Society guidelines for hypertension management 1999: summary. *BMJ*.319: 630-635

Ranta P, Jouppila P, Spalding M, et al. 1995. The effect of maternal obesity on labour and labour pain. *Anaesthesia*. 50(4): 322-6.

Raymond EG, Cnattingius S, Kiely JL. 1994. Effects of maternal age, parity, and smoking on the risk of stillbirth. *Br J Obstet Gynaecol*. 101(4): 301-6.

Read AW, Stanley FJ. 1993. Small-for-gestational-age term birth: the contribution of socio¬economic, behavioural and biological factors to recurrence. *Paediatr Perinat Epidemiol.* 7(2): 177-94.

Renfrew MJ, Hannah W, Albers L, et al. 1998. Practices that minimize trauma to the genital tract in childbirth: a systematic review of the literature. *Birth*. 25:143–160.

Roberts CL, Algert C, Peat B, Tracy S, Douglas I, 2002. Trends in labour and birth interventions among low-risk women in an Australian population. *ANZJOG*. 42(2): 176-181.

Roberts CL, Tracy S, Peat B. 2000. Rates for obstetric intervention among private and public patients in Australia: population based descriptive study. *BMJ*. 321(7254): 137-141.

Rosso P, Salas SP. 1994. Mechanisms of fetal growth retardation in the underweight mother. *Adv Exp Med Biol.* 352: 1-9.

Rowley, M, Hensley, M, Brinsmead, M, Wlodarczyk, J. 1995. Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *The Medical Journal of Australia*. 163 (9): 289-293.

Rush RW, Keirse MJNC, Howat P, et al. 1976. Contribution of preterm delivery to perinatal mortality. *BMJ*. 2:965–968.

Rust OA, Atlas RO, Reed J, et al. 2001. Revisiting the short cervix detected by transvaginal ultrasound in the second trimester: Why cerclage therapy may not help. *Am J Obstet Gynecol*. 185:1098–1105.

Sandall J; Davies J; Warwick C. 2001. *Evaluation of the Albany Midwifery Practice: Final Report.* Florence Nightingale School of Nursing and Midwifery, Kings College London..

Schytt E, Lindmark G, Waldenström U. 2005. Physical symptoms after childbirth: prevalence and associations with self-rated health *BJOG*. 112 (2): 210–217

Senate Community Affairs Reference Committee. 1999. *Rocking the Cradle:*

a report of childbirth procedures. Canberra. Commonwealth of Australia. 1999

Seubert DE, Huang WM, Wasserman-Hoff R. 2007. Medical legal issues in the prevention of prematurity. Clin Perinatol. 34(2):309-18.

Shiono P, Klebanof MD, Carey JC. Midline episiotomies: more harm than good? *Obstet Gynaecol* 1990; 75:756–770.

Shorten A, Shorten B Episiotomy in NSW hospitals 1993-1996: Towards understanding variations between public and private hospitals *Australian Health Review*. 1999; 22(1): 19-32.

Sibai BM. The HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets): much ado about nothing? *Am J Obstet Gynecol* 1990; 162(2): 311-6.

Sikorski J, Renfrew M. (2000) Support for breastfeeding mothers In: *The Cochrane Library*. Issue 4 Oxford 2000.

Simhan HN, Caritis SN. Prevention of preterm delivery. N Engl J Med 2007;357:477-487

Simkin P 1991. Just another day in a woman's life? Women's long-term perceptions of their first birth experience. *Birth*. 18(4): 203-10.

Sleep J, Grant A, Garcia J, et al. 1984. West Berkshire perineal management trial. *BMJ*. 298:587–690.

Smit Y, Scherjon SA, Knuist M, Treffers PE. 1998. Obstetric outcome of elderly low-risk nulliparae. *Int J Gynaecol Obstet*. 63(1):7-14.

Smit BJ, Boer K, van Huis AM, et al. 1994. Cocaine use in pregnancy in Amsterdam. *Acta Paediatr Suppl.* 404: 32-5.

Smith R. 2007. Parturition. *N Engl J Med* 356: 271-283

Spitzer M. 1995. Birth Centres: Economy, Safety and Empowerment *Journal of Nurse-Midwifery*. 40(4): 371-375 .

Sultan AH, Kamm MA, Bartram CI, et al. 1994. Perineal damage at delivery. *Contemp Rev Obstet Gynaecol* 6:18–24.

Sultan AH, Kamm MA, Hudson CN. 1993. Anal sphincter disruption during vaginal delivery. *N Engl J Med*. 329:1905–1911.

Sultan AH, Monga AK, Kumar D, et al. 1999. Primary repair of anal sphincter using the overlap technique. *Br J Obstet Gynaecol*. 106:318–323.

Sung IK, Vohr B, Oh W. 1993. Growth and neurodevelopmental outcome of very low birth weight infants with intrauterine growth retardation: comparison with control subjects matched by birth weight and gestational age. *J Pediatr.* 123(4): 618-24.

Taddei S, Virdis A, Mattei P, et al. 1995. Aging and endothelial function in normotensive subjects and patients with essential hypertension. *Circulation*. 91(7): 1981-7.

Tew M. 1986. Do obstetric intranatal interventions make birth safer? *Br J Obstet Gynaecol.* 93: 659-674

Thompson J.F., Roberts C.L., Currie M, Ellwood D.A. 2002. Prevalence and Persistence of Health Problems After Childbirth: Associations with Parity and Method of Birth. *Birth*. 29(2): 83-94.

Tracy SK Tracy MB. 2003. Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data. *BJOG*. 110:717-724

Tracy SK, Sullivan ES, Tracy MB. 2007. Admission of term infants to neonatal intensive care: A population based study. *Birth*. 34(4):301-307

Turnbull, D, Holmes, A, Shields, N, Cheyne, H, Twaddle, S, Harper-Gilmour, W, McGinley, M, Reid, M, Johnston, I, Geer, I, McIlwaine, J, Burnett, Lunan, C. 1996. Randomised controlled trial of efficacy of midwife - managed care. *Lancet*. 348(9022): 213-218.

van der Ham DP, Nijhuis JG, Mol BW, van Beek JJ, Opmeer BC et al. 2007. Induction of labour versus expectant management in women with preterm prelabour rupture of membranes between 34 and 37 weeks (the PPROMEXIL-trial). *BMC Pregnancy Childbirth*. 6; 7:11

van Pampus, MG, Wolf, H, Westenberg, SM, van der Post, JA, Bonsel, GJ, Treffers, PE. 1998. Maternal and Perinatal Outcome After Expectant Management of the HELLP Syndrome Compared With Pre-Eclampsia Without HELLP Syndrome. *Obstetrical & Gynecological Survey* 53(8): 462-464,

Vazquez JC, Villar J. 2003. Treatments for symptomatic urinary tract infections during pregnancy. *Cochrane Database of Systematic Reviews* 2003, Issue 3. Art. No.: CD002256. DOI: 10.1002/14651858.CD002256 (accessed 28th August 2008)

Vercellini P, Zuliani G, Rognoni MT, et al. 1993. Pregnancy at forty and over: a case control study. *Eur J Obstet Gynecol Reprod Biol* 48(3): 191-5.

Villar J, Bergsjo P, Carroli G, Gulmezoglu M. 2003. The WHO new antenatal care model: the way forward. *Acta Obstet Gynecol Scand.* 82(11): 1065-6.

Villar J, Bergsjø P. 1997. Scientific basis for the content of routine antenatal care I. Philosophy, recent studies, and power to eliminate or alleviate adverse maternal outcomes. *Acta Obstet Gynecol Scand* 1997; 76: 1-14.

Villar J, Farnot U, Barros F, et al. 1992. A randomized trial of psychosocial support during high-risk pregnancies. *N Engl J Med.* 327: 1266–1271.

Villar J, Carroli G, Zavaleta N, Donner A. 2007. Maternal and neonatal individual risks and benefits associated with caesarean delivery: multicentre prospective study. *BMJ*. 335(7628):1025.

Waldenstrom U, Hildingsson I, Robertsson C, Radestad, I (2004). A negative birth experience: prevalence and risk factors in a national sample. *Birth*. 31(1): 17-27

Wagner M. Midwifery in an Industrialized World. J of the Canadian Society of Obstetrics and Gynecology 1998; 20;13:1225-34

Wagner M. Choosing Caesarean Section. The Lancet 2000; 356: 1677-80

Wagner M. 2001. Fish can't see water: the Need to Humanize Birth. *Int J Gynecol Obstets*. 75:s25-37

Wagner M. 1994. *Pursuing the birth machine: the search for appropriate technology*. Camperdown Australia: ACE Graphics.

Waldenstrom U, Turnbull DA. 1998. Systematic review comparing continuity of midwifery care with standard maternity services *British Journal of Obstetrics & Gynaecology*. 105 (11): 1160-70

WHO. 1998. World Health Organisation. Care in Normal Birth: a practical guide. http://www.who.int/reproductivehealth/publications/MSM_96_24/care_in_normal_birth_practical_guide.pdf

Wiegers TA, Keirse MJNC et al. 1996. Outcome of planned home and planned hospital births in low risk pregnancies in the Netherlands. *BMJ*. 3 13:1309-13 .

Wildschut HIJ. ten Hoope-Bender P, Borkent-Polet M, Traas H, van Agt, HME, de Kroon ML. A.,van der Maas PJ. 1999. Practice variation of test procedures reportedly used in routine antenatal care in The Netherlands. *Acta Obstetricia et Gynecologica Scandinavica*. 78(1): 27-32

Williams FL, Florey C du V, Mires GJ, et al. 1998. Episiotomy and perineal tears in low-risk UK primigravidae. *J Pub Health Med.* 20:422–427.

Wolleswinkel-Van Den Bosch, J H, Vredevoogd CB, Borkent-Polet M, Van Eyck J, Fetter W.P. F, Lagro-Janssen TLM, Rosink IH, Treffers PE, Wierenga H et al. 2002. Substandard factors in perinatal care in The Netherlands: a regional audit of perinatal deaths. *Acta Obstetricia et Gynecologica Scandinavica*. 81(1): 17-24.

Zasloff E, Schytt E, Waldenström U. 2007. First time mothers' pregnancy and birth experiences varying by age. Acta Obstet Gynecol Scand. 86(11):1328-36

Zhang J, Villar J, Sun W, Merialdi M, Abdel-Aleem H et al 2007. Blood pressure dynamics during pregnancy and spontaneous preterm birth. Am J Obstet Gynecol.197(2):162.e1-6

Relevant websites: (accessed August 29th 2008)

Association for Improvement in Maternity Services (AIMS): http://www.aims.org.uk/

Australian Commission on Safety and Quality in Health Care: www.safetyandquality.org/internet/safety/publishing.nsf

Breastfeeding: http://www.mothersdirect.com.au/prod48.htm

Evidence based guidelines for midwifery care
http://www.rcm.org.uk/college/standards-and-practice/practice-guidelines
Google Scholar:
http://scholar.google.com.au
Midwives Information and Resource Service (MIDIRS):
http://www.midirs.org.
Waterbirth:
http://www.birthinternational.com/product/video/title-w.html

Appendix A:

Appendix A:

WHEN A WOMAN CHOOSES CARE OUTSIDE THE RECOMMENDED *ACM NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL*

The following document was developed from a similar document published by the College of Midwives of Ontario 'When A Client Chooses Care Outside Midwifery Standards of Practice' January 1994, Revised September 22, 2004. The document aims to assist midwives to support a woman's decisions after a discussion regarding informed choice has taken place.

A woman in the care of midwives may occasionally choose not to accept a care pathway as recommended in the Australian College of Midwives' (ACM's) *National Midwifery Guidelines for Consultation and Referral* (the *Guidelines*). It is also possible that a woman in midwifery care may choose care that the midwife judges is beyond her ability to safely manage, or decline care that the midwife considers essential for the provision of safe care.

Ethical principles underlying health care and health law emphasize the importance of respecting the autonomy of those receiving health care and the rights of individuals to choose among alternative approaches, weighing risks and benefits according to their needs and values. Midwives, like all health professionals, are responsible for being clear about their scope of practice and limitations, giving recommendations for care if appropriate and for informing women about risks, benefits and alternative approaches.

Midwives are also responsible for providing care consistent with the national professional standards for midwives. These include national midwifery competency standards[6] , codes of ethics[7] and professional conduct[8] , and relevant state or territory based regulatory requirements for midwifery practice.

Should a situation arise in which the woman chooses care outside the recommendations in the *Guidelines* the midwife must engage with the woman and her family and with hospital staff through identified channels where applicable, in a thorough discussion of the request, looking for options and resolutions within midwifery professional standards to address the woman's needs.

[6] Australian Nursing and Midwifery Council, 2006, National Competency Standards for the Midwife
[7] Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation, 2008, Code of Ethics for Midwives in Australia
[8] Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation 2008, Code of Professional Conduct for Midwives in Australia

In exceptional circumstances, the issue may not be able to be resolved to both the woman's and the midwife's satisfaction. This appendix is meant to assist midwives in addressing those occasions when a solution within the recommended care pathways of the *Guidelines* cannot be found.

When a midwife advises a woman that a certain course of action must be followed in order to comply with midwifery standards of practice, and the woman refuses to follow that advice, the midwife should:

1. **Advise** the woman not only of the recommended guideline but also of the rationale and the evidence behind the guideline in this case;
2. **Consult** with at least one of the following:
   a. another midwife,
   b. a physician,
   c. a peer review group or
   d. an ethicist.

   Consultation should include discussion of appropriate next steps if the woman continues to choose care outside the recommended guideline, and consideration of the safest and most ethical course under these circumstances, i.e. continuation of primary midwifery care or referral of care;
3. **Share the advice** of the consultation with the woman; and
4. **Document** in the accompanying **care plan** and the woman's notes the informed choice process, when and with whom the consultation took place, the recommendations arising from the consultation, the date on which the woman was advised of the recommendations and the woman's response.

After completing steps 1 to 4 above, if a satisfactory resolution has not been achieved for the woman or the midwife, the midwife has two choices. Using her ethical judgment, the midwife must decide to either:

a) Continue care and respect the woman's choice for her care and:

1. continue making recommendations for safe care;
2. continue to engage other caregivers as appropriate who might become involved in provision of care (eg. Hospital staff, other midwives in practice);
3. continue to document all discussions and decisions.

OR

b) Discontinue care:

1. clearly communicate to the woman that the midwife is unable to continue to provide care;

2. send a written referral that confirms the termination of care by a date that provides the woman with a specific amount of time to find another caregiver. This time should be reasonable and will vary according to location and circumstance. If, during this time, the woman cannot arrange alternate care, the midwife should make a reasonable attempt to find a caregiver who is willing to see the woman and provide alternate care;
3. maintain a copy of this letter including the proof of receipt, in the woman's health record.

In the course of labour or urgent situations, the midwife may not refuse to attend the woman. When the steps for discontinuing care of the woman have not been undertaken or completed prior to the onset of labour, the midwife must attend the woman.

In circumstance where a woman refuses emergency transport or transfer of care in the course of active labour, the midwife must remain in attendance as the primary care provider, and may be called upon to deal with an urgent situation, or one that is not within the midwife's standards, scope or abilities to perform.

In these situations the midwife should:

1. Attempt to provide care within professional standards
2. Attempt to provide care to the best of her ability
3. Attempt to access appropriate resources and/or personnel to provide any needed care

Care Plan WHEN A WOMAN CHOOSES CARE OUTSIDE THE RECOMMENDED *ACM GUIDELINES*	Affix patient label

Reason for medical/other consultation:

_____

_____

_____

Discussed with: _____ **Date:** _____
name

☐ consult ☐ in person ☐ transfer
☐ phone

Care Plan:_____

_____

_____

_____

_

☐ Midwifery lead carer ☐ Medical lead carer ☐ Other lead carer

Date and agreed by:

Date: _____ ☐ _____ Woman

Date: _____ ☐ _____ Medical Consultant

Date: _____ ☐ _____ Midwife

Source: We would like to acknowledge the Children, Youth and Women's Health Service Government of South Australia and the Women's and Children's Hospital, Adelaide, South Australia for the template on which this document is based.

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Ms Debra Cerasa	Royal College of Nursing Australia
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Declined to nominate	Australian Indigenous Doctors Association
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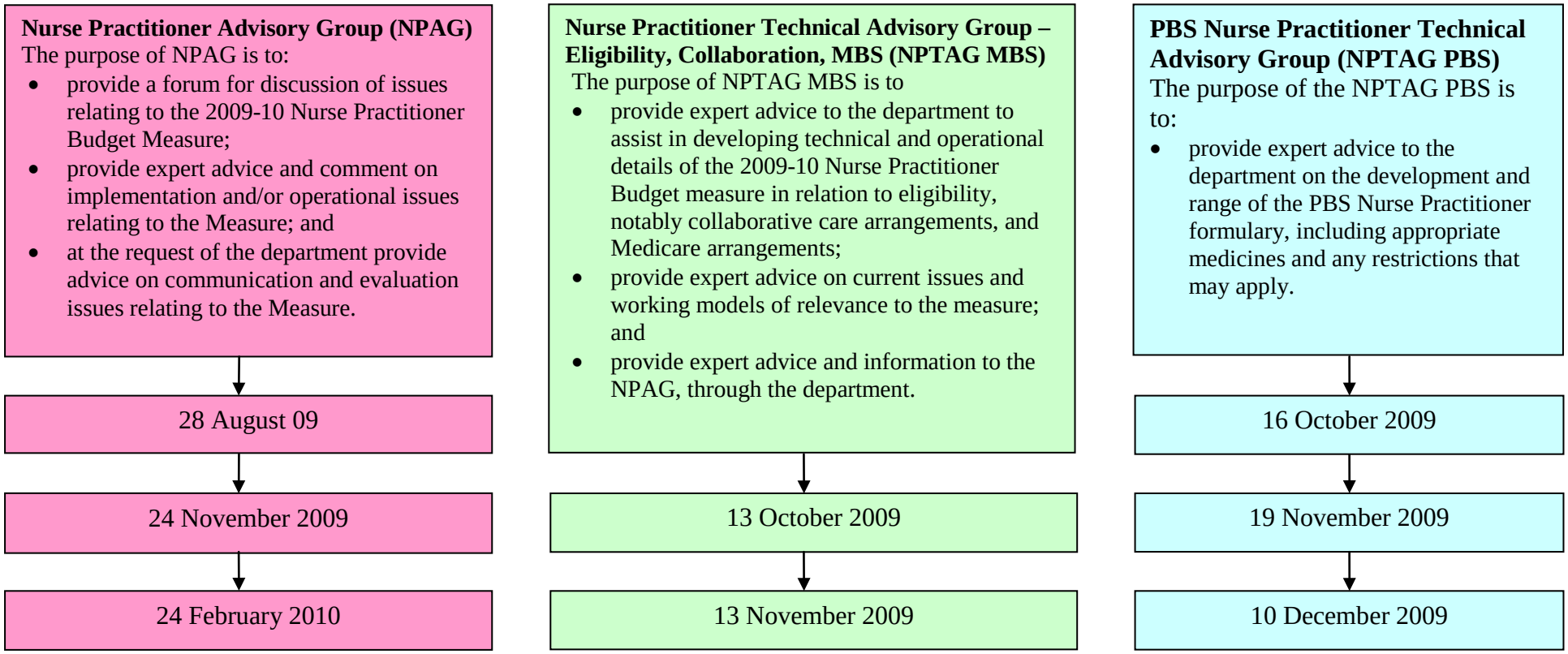
Dr Alison Edwards Mrs Judy Bagg	Australian General Practice Network
Dr Robert Clarke Mrs Cassandra Holland	Australian Practice Nurse Association
Ms Darlene Cox	Consumers Health Forum
No nominee	Australian Private Hospitals Association
Ms Helen Hopkins	National Rural Health Alliance
Adj Prof Jenny Beutel (SA)	Representative of States and Territory Government
Ms Cathie Nesvadba (QLD)	Representative of States and Territory Government
Ms Anne Develin	Pharmacy Guild of Australia
Mr Steve Sant	Rural Doctors Association of Australia

DIAGRAM REPRESENTING DEPARTMENT OF HEALTH AND AGEING CONSULTATIONS WITH NURSE PRACTITIONER ADVISORY GROUPS ON ELIGIBILITY, COLLABORATION AND MBS, AND PBS



Nurse Practitioner Technical Working Groups

MBS
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ANMC representative
Cassie Holland
Julianne Bryce - Australian Nursing Federation
Lesley Salem (happy with either group)
Andrew Cashin
Elissa O'Keefe - RCNA
Dr Steve Hambleton - AMA
Helen Hopkins - The National Rural Health Alliance

PBS
Lindee Russel - Consumers Health Forum of Australia
Cassie Holland
Jeff Ayton - Australian College of Rural and Remote Medicine
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