phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Shared Maternity Care Workshop 1: Declining recommended maternity care and Abnormal ultrasound findings

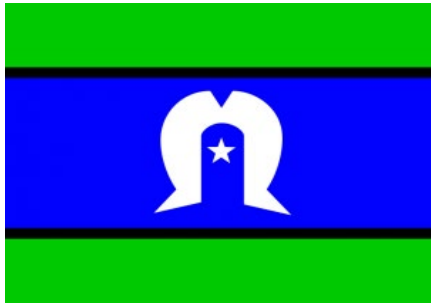
Tuesday 16 September 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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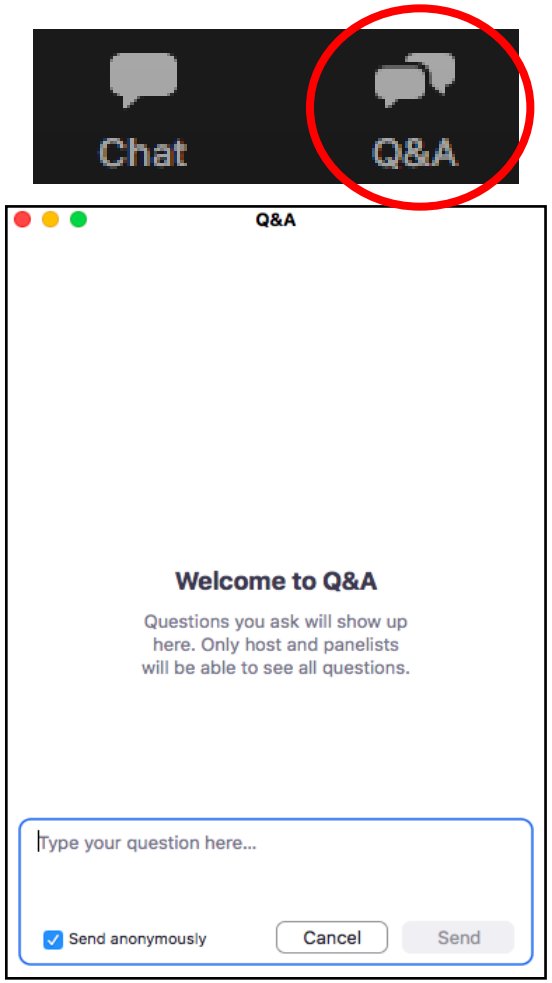

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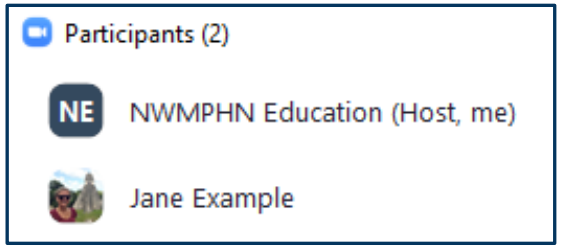

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Collaboration

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Northern Health

Shared Maternity Care Collaborative

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General Practice Integration Manager, Skye Spencer
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Speakers

Dr Gill Paulsen is the Clinical Director of Obstetrics for the Mercy Hospital for Women. In addition to this senior leadership role, she works as an Obstetrician in both public and private settings. Gill has a focus on quality improvement, is closely involved with adverse patient safety event review processes, manages obstetric patient feedback for the hospital, and also runs the Obstetric Debrief Clinic. Her driving goal is to provide patient centred, collaborative, safe care to mothers and families

Dr Peter Jurcevic has 30 years of clinical experience in Obstetrics and Gynaecology. He is High Risk Pregnancy trained and has delivered 7000 babies to date. Head of Unit at The Women's Hospital in Melbourne and member of the Frances Perry House MAC. He has provided over 500+ lectures, is a research collaborator at the hospital and University of Melbourne, and on the side, an avid cyclist, surfer, husband, and father of 3.

HealthPathways Melbourne

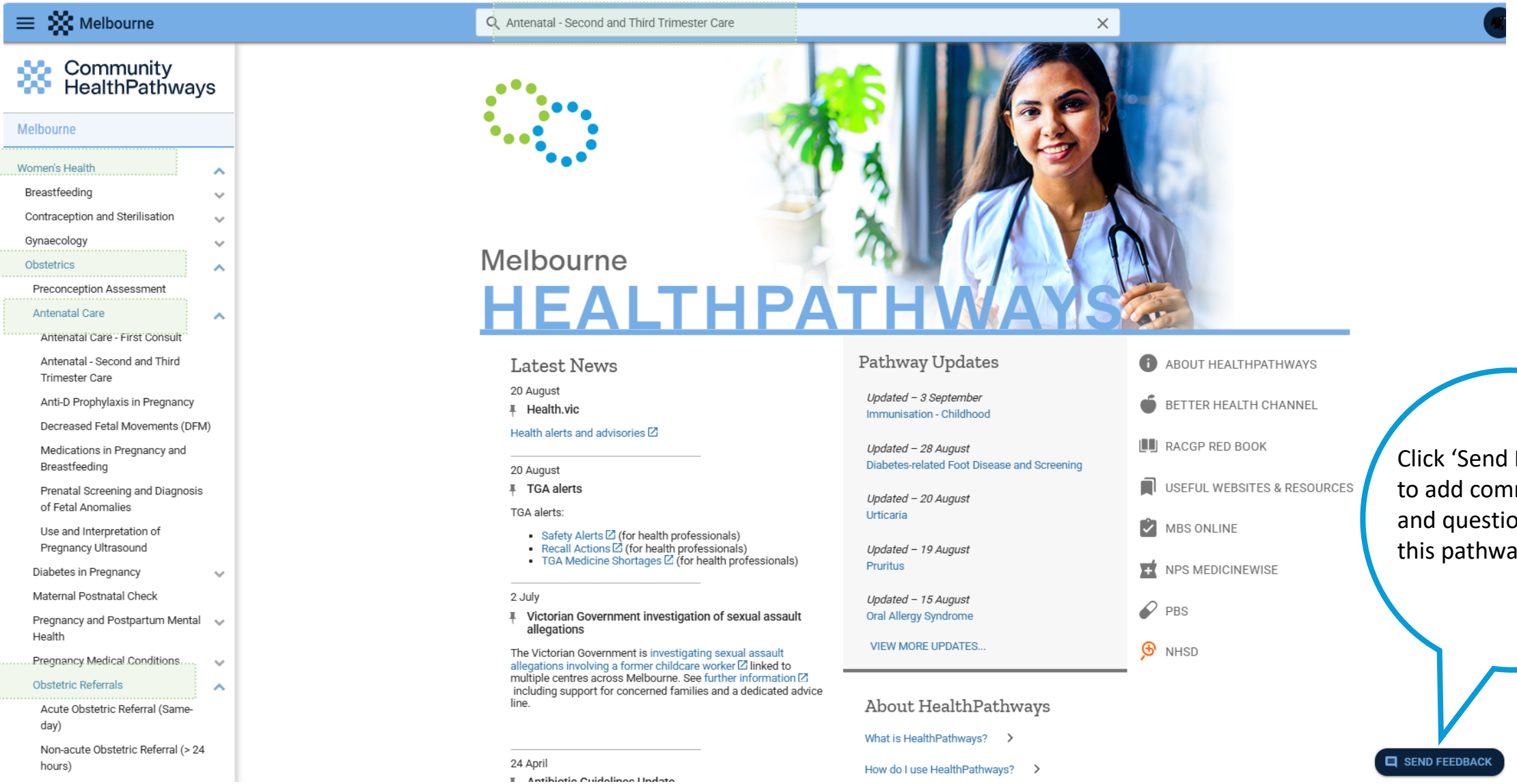
Shared Maternity Care Workshop 1: Declining recommended maternity care and Abnormal ultrasound findings

16 September 2025

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways – Antenatal - Second and Third Trimester Care



Click 'Send Feedback' to add comments and questions about this pathway.

HealthPathways – Antenatal - Second and Third Trimester Care

HealthPathways Melbourne

Assessment

1. Ensure the initial assessment of patients has been completed according to the Antenatal Care – First Consult pathway. At each subsequent appointment:
   - confirm the chosen model of maternity care.
   - ensure patient has a pregnancy booking and appointments have been arranged and/or attended.
   - check that all results from the previous antenatal checks have been provided to the patient and actioned.
2. Consider the needs of priority populations.
3. Ask about:
   - symptoms of concern.
   - common conditions in pregnancy.
   - potentially sensitising events for patients who are rhesus (Rh-D) negative. If a sensitising event has occurred, follow the Anti-D Prophylaxis in Pregnancy pathway.
4. Perform a maternal and fetal well-being check.
5. Review the patient's lifestyle and well-being:
   - Assess smoking, alcohol consumption, and substance use.
   - Assess diet and exercise.
6. Review psychosocial risk factors and screen for domestic and family violence.
7. Review mental health and well-being – consider administering the Edinburgh Postnatal Depression Scale.
8. Arrange routine investigation if not already performed:
   - 20 to 22 weeks

     Routine checks – 20 to 22 weeks

     Mid trimester morphology ultrasound. Request measurement of cervical length as it is a risk factor for preterm birth.
   - 24 to 28 weeks
   - 35 to 37 weeks
9. Arrange additional investigations according to presentation:
   - If suspected cholestasis in pregnancy – bile acids/LFTs. See also Skin Conditions (Rash and Itch) in Pregnancy.
   - If suspected UTI – MSU microscopy, culture, and sensitivity (MCS). See also UTI and Asymptomatic Bacteriuria in Pregnancy.

Click on the drop-down arrow to view supplementary information

Antenatal - Second and Third Trimester Care

Management

1. Refer for acute obstetric review if:
   - the patient reports a change or decrease in fetal movements at > 24 weeks.
     - Send the patient for immediate review and CTG.
     - Do not advise them to eat or drink something to stimulate movement, or to rest and monitor movements for a period of time.
   - unable to detect fetal heart beat after 24 weeks.
   - vaginal bleeding and/or abdominal or pelvic pain.
   - suspected cholestasis of pregnancy (itch with no rash and abnormal LFT/bile acids).
   - open cervix.
   - cervical length < 25 mm (transvaginal) on mid-trimester morphology scan.
   - fetal growth restriction (FGR) detected < 31 weeks' gestation with the likelihood of requiring preterm birth.
   - patient has hypertension (systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg) or symptoms of pre-eclampsia. See Hypertension in Pregnancy and Postpartum.
   - twin-twin transfusion syndrome or fetal death of monochorionic twin.
2. Refer for non-acute obstetric review and if possible, arrange urgent biometric obstetric ultrasound beforehand if:
   - suspected intrauterine growth restriction (fundal height is > 2 cm smaller than expected or static over weeks).
   - suspected macrosomia (fundal height is > 2 cm greater than expected dates).
3. Be aware of the statewide referral criteria for management at a level 6 maternity service. Regional or rural doctors should contact the closest level 5 maternity service first to discuss options.
4. Ensure all test results have been received and reviewed. Follow up on abnormal results.
5. Offer influenza vaccination, pertussis vaccination, and COVID-19 vaccination to all pregnant and breastfeeding patients.
6. Confirm anti-D has been administered at 28 and 34 weeks if the patient is Rh D-negative.
7. Confirm patients are taking low dose aspirin (and calcium if dietary intake insufficient) for prevention of pre-eclampsia in patients at moderate or high risk of pre-eclampsia. See also Hypertension in Pregnancy and Postpartum.
8. Discuss interventions available for cessation of smoking in pregnancy.
9. Advise that there is no safe limit of alcohol consumption in pregnancy.
10. Discuss going to sleep on the side (not back) after 28 weeks. See Stillbirth Centre of Research Excellence – Going To Sleep On Your Side From 28 Weeks.
11. Provide mental health support as appropriate. Advise patient of online resources e.g.:
    - Centre of Perinatal Excellence (COPE)
    - Gidget Foundation
    - PANDA
    - The Parent-Infant Research Institute (PIRI)

HealthPathways – Non-acute Obstetric Referral

Non-acute Obstetric Referral (> 24 hours)

If advice about management is needed, page the public hospital on-call obstetric registrar (usually via hospital switchboard), or contact a private specialist via their consulting rooms.

See also:

- Acute Obstetric Referral (Same-day)
- Early Pregnancy Assessment Service (EPAS)
- Obstetrics pathways

Public

Public Hospitals

1. Check the referral criteria including Statewide Referral Criteria for referrals to Level 6 Maternity services.
2. Confirm that the patient is aware of the need for referral and is willing for this to take place. If the patient is not competent to consent, refer to the consent process.
3. Prepare the required referral information and mark the referral as urgent or routine.
4. Refer to the service.
   - If the patient needs to be seen before the scheduled appointment, contact the service where patient is booked to birth. Speak with clinic midwifery or obstetric staff, who can organise urgent clinic review. Then send a referral marked as urgent.
   - Specialist clinics may request referral to a named specialist or Head of Unit.
   - Consider:
     - General Practice Referral Template
     - Hospital GP Liaison
     - Aboriginal Hospital Liaison Officer
   - See also Shared Care Guidelines referral information.

     Eastern Melbourne

     North Western Melbourne

     Statewide
5. Advise the patient:
   - that providers may charge fees.
   - to advise of any change in circumstance as this may affect the referral.

North Western Melbourne

Mercy Health - Werribee Mercy Hospital Antenatal Clinics Level 4 Maternity Service	Werribee, Wyndham
Northern Health Antenatal Care Level 5 Maternity Service	Epping, Whittlesea
Northern Health Medical Obstetrics	Epping, Whittlesea
The Royal Women's Hospital Maternity Care Clinics Level 6 Maternity Service	Parkville, Melbourne

REFERRAL OPTIONS

Fax (03) 8345-3036

Referral form(s) Referral Form

Service-specific criteria

Inclusion criteria:

- Parkville
  - Women with high risk pregnancies requiring tertiary care from the north-west of Victoria
  - Women who are pregnant and fall within the Women's local metropolitan area
- Sandringham
  - Women with low risk pregnancies who fall within the Sandringham Hospital local area
  - singleton or dichorionic twin pregnancy
  - Parity <5
  - Body Mass Index (BMI) > 17 and < 37.9 at date of referral

Exclusion criteria:

- Sandringham
  - Women with high risk pregnancies

Information for referrer

Referral advice: Phone Obstetric registrar via switchboard.

Head of unit: Dr Jenny Ryan, Director of Maternity Services

When ordering tests for a patient (or a potential patient) of the Women's, **add RWH in the cc box on your pathology request slip**. This will enable electronic transfer of results to The Royal Women's Hospital electronic medical record system

Relevant and related pathways

Antenatal Care
Preconception Assessment
Antenatal Care - First Consult
Antenatal - Second and Third Trimester Care
Anti-D Prophylaxis in Pregnancy
Prenatal Screening and Diagnosis of Fetal Anomalies
Use and Interpretation of Pregnancy Ultrasound

Pregnancy Medical Conditions
Anaemia in Pregnancy
Asthma in Pregnancy
Hypertension in Pregnancy and Postpartum
Thyroid Disease in Pregnancy

Diabetes in Pregnancy
Hyperglycaemia in Pregnancy
Pre-pregnancy Planning for Type 1 and Type 2 Diabetes
Type 1 and Type 2 Diabetes and Pregnancy

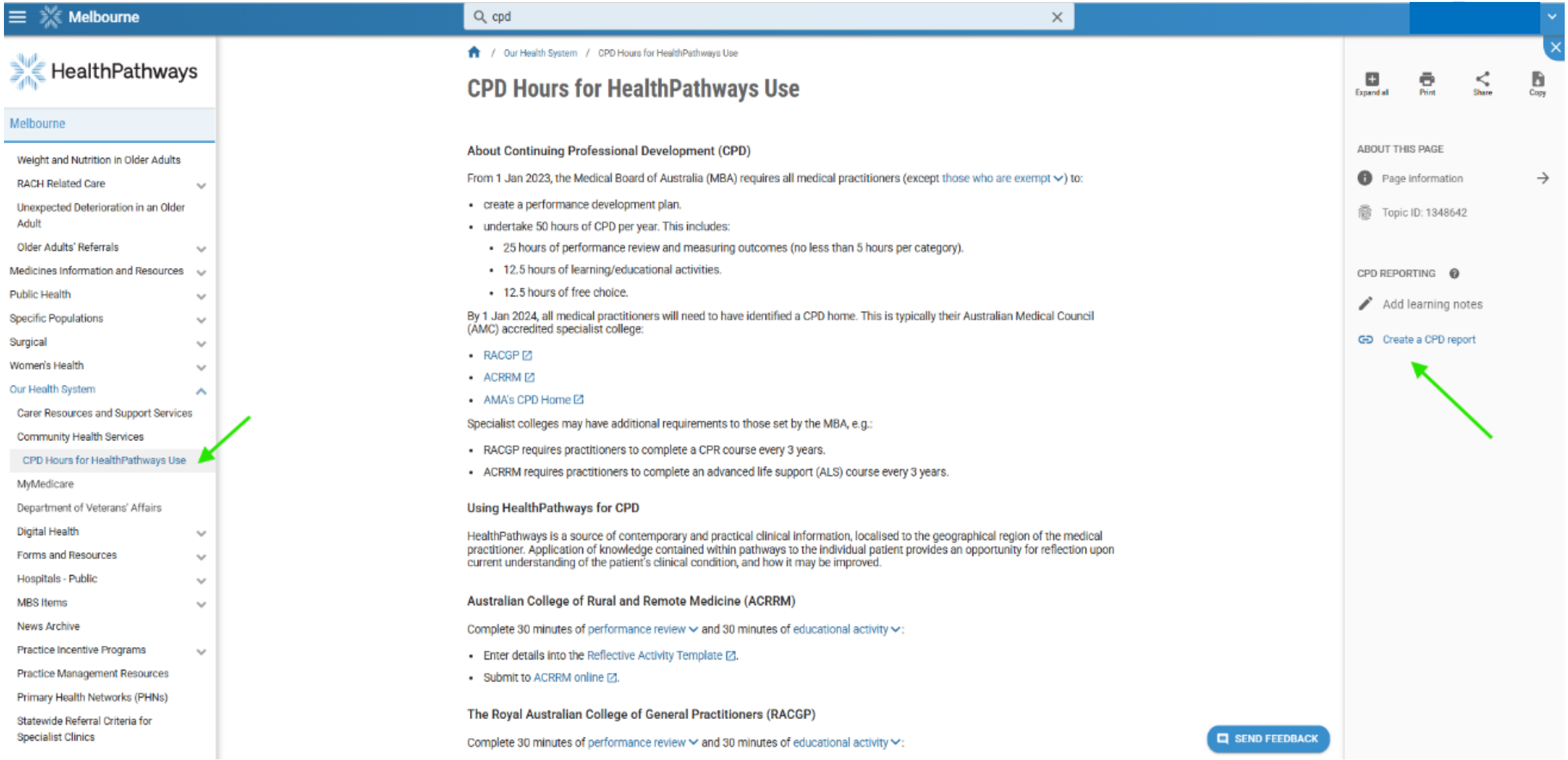
Obstetrics
Maternal Postnatal Check
Pregnancy and Postpartum Mental Health

Legal and Ethical
Consent

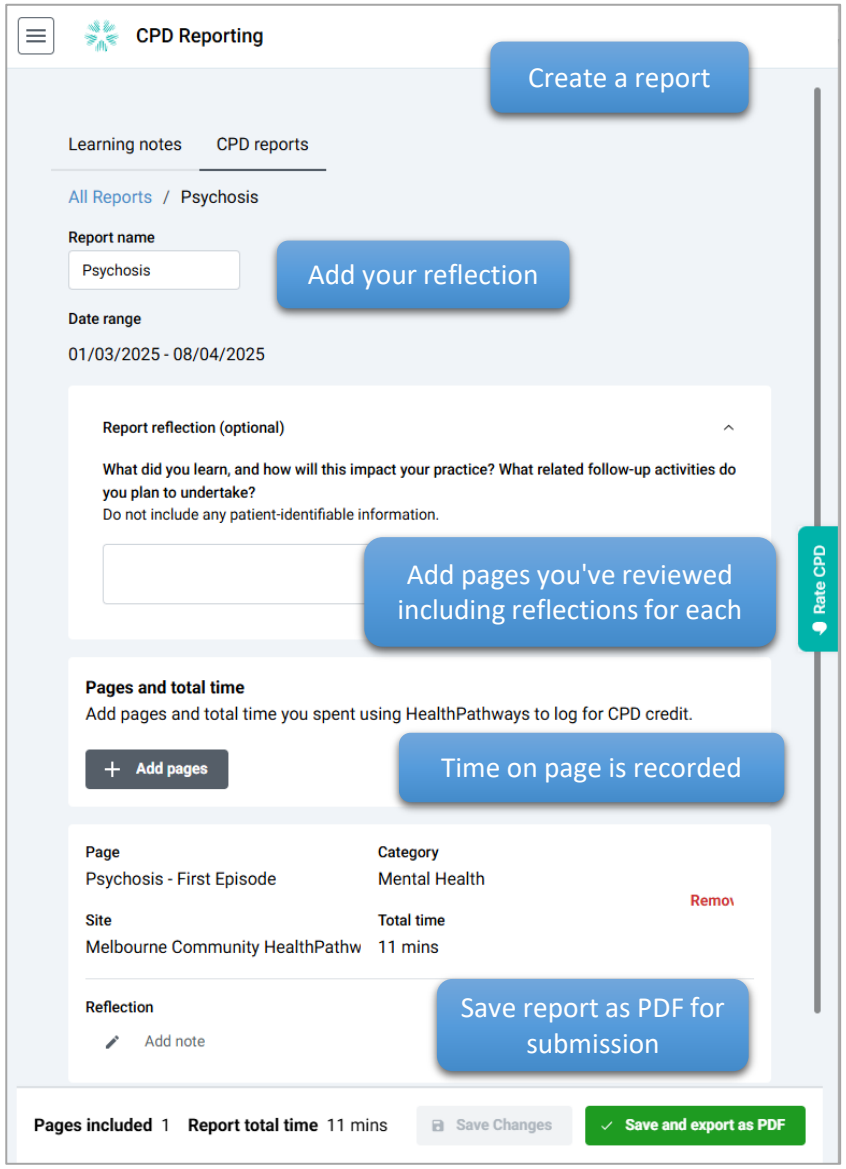
Obstetric Referrals
Pregnancy Medical Conditions
Acute Obstetric Referral or Admission (Same-day)
Non-acute Obstetric Referral (> 24 hours)
Early Pregnancy Assessment Service (EPAS)
Pregnancy Booking
Statewide Referral Criteria for Specialist Clinics

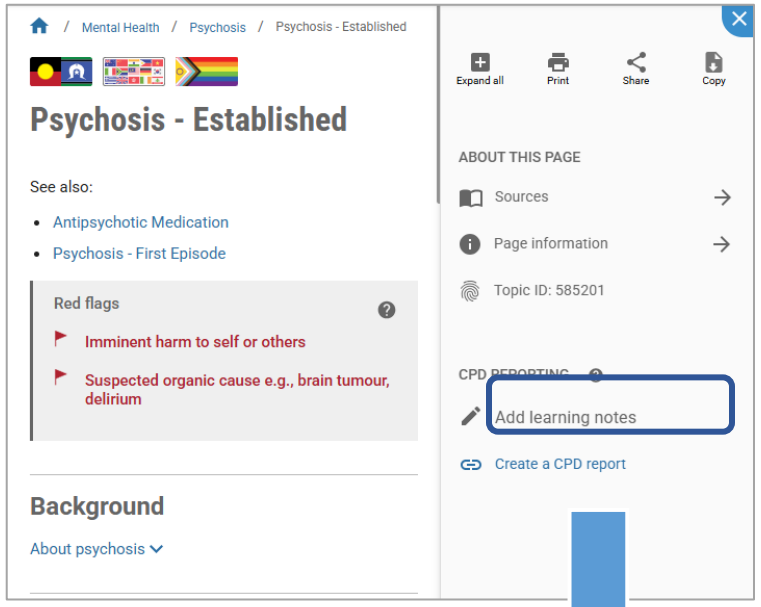
CPD Hours for HealthPathways Use

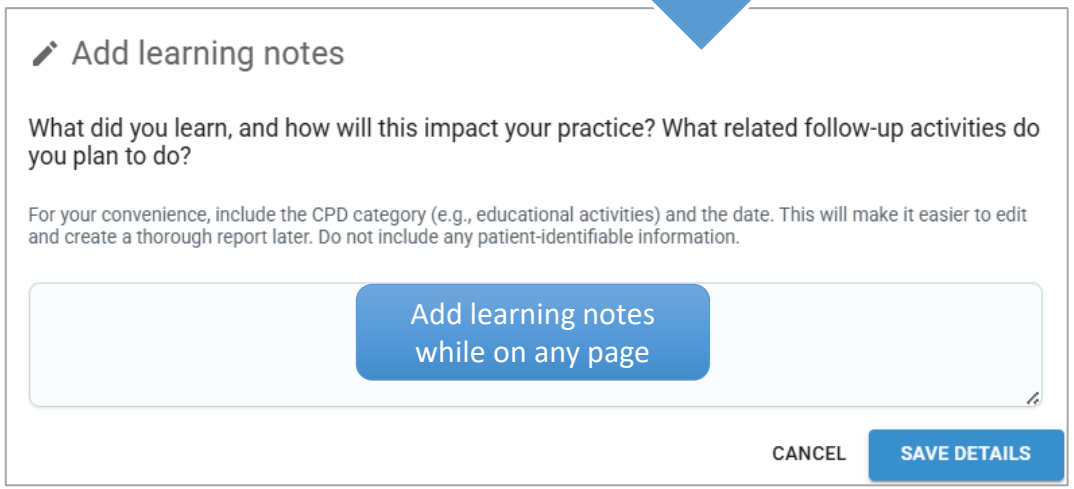
HealthPathways – CPD Hours for HealthPathways Use



How to use the CPD reporting tool:







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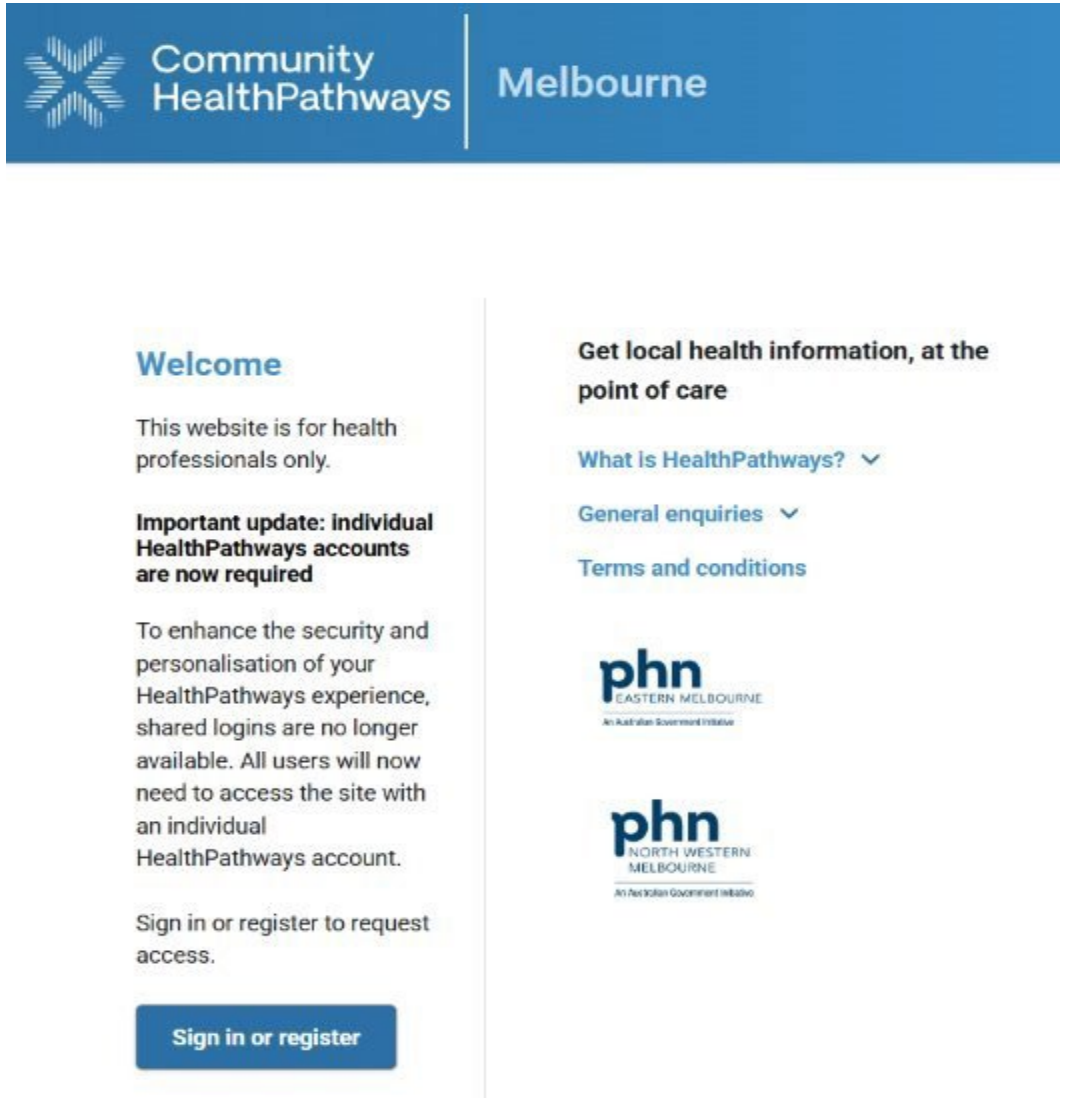
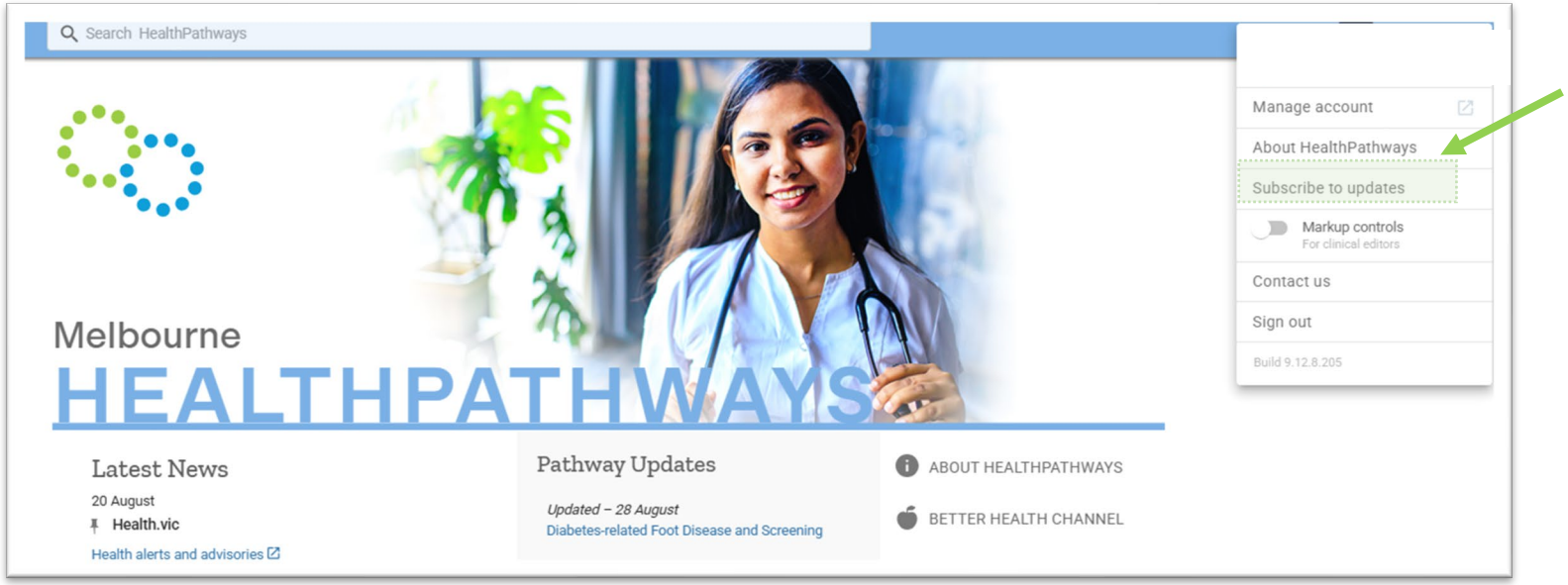


HealthPathways Bulletin

Access the latest case study- Assistance with pregnancy



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Case study highlight

Lucy, 32, is a new patient presenting with light vaginal bleeding. She attends with her partner Jack and reports a positive home pregnancy test, estimating she is 6 weeks pregnant.

The GP consults the Bleeding during Pregnancy Pathway and arranges urgent investigations: quantitative β-hCG, FBE, blood group, and antibody screen. A transvaginal ultrasound is scheduled, along with routine antenatal tests as per the Antenatal Care – First Consult Pathway.

Partnering with women:

- Birth trauma and patients declining recommended care

Dr Gill Paulsen, Clinical Director of Obstetrics, Mercy Hospital for Women
www.drgillpaulsen.com.au Email: gpaulsen@mercy.com.au

Overview

- Birth trauma
- Lessons from Debrief Clinic
- Postnatal care options
- Patients who decline recommended care framework and key principles
- Examples of patient centred obstetric intervention- OVBB

THE AGE

National Victoria Coroners Court of Victoria

Newborn died after lengthy 'freebirth' in home pool

Erin Pearson
August 7, 2025 — 8.32pm

Save Share A A A

A newborn died after her mother spent close to 39 hours in a hired, bacteria-filled pool at home giving birth without medical help.

A coroner said the 41-year-old woman's prolonged "freebirth" probably contributed to the preventable death of her baby in 2022.

A finding on the death, released on Thursday, said the mother fell pregnant in March 2022 and did not see a doctor for regular antenatal tests or scans but reported feeling fantastic.

Midwives express remorse after home birth and Victorian baby's death

By Anna McGuinness and Laura Mayers

ABC Central Victoria | Courts

Thu 31 Jul

An inquest is examining if the death of 'Baby R' was preventable. *(ABC News: Darryl Torpy)*

In short:

A coronial inquest is being held into the death of a baby boy after a home birth in Bendigo.

'Baby R' died from perinatal hypoxia in August 2022 after his mother was rushed to hospital for an emergency caesarean.

The inquest heard more women in central Victoria had chosen to "free birth" since the midwives involved were directed not to practice private midwifery.

abc.net.au/news/baby-death-home-birth-coroni... Share article

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Woman charged following death of baby during home birth - Newsletter

Thursday, 14 August 2025 03:35:37 PM

A woman who worked as a midwife will face court today charged with manslaughter following the death of a baby during a home birth near Newcastle last year.

On Wednesday 2 October 2024, a privately practicing midwife attended a home in Wallsend to assist a woman with a home birth.

Police will allege in court that over the following two days, the midwife did not act upon signs of complications and requests by the woman to attend hospital.

On Friday 4 October 2024, the woman attended John Hunter Hospital where the baby was delivered by emergency caesarean.

Police have been told that the mother and baby suffered significant medical complications as a result of the incident.

On Thursday 10 October 2024, the baby boy died in hospital, and police attached to Newcastle City Police District commenced inquiries under Strike Force Girona.

Following extensive inquiries by strike force detectives, police arrested a 36-year-old woman at Newcastle Police Station about 8.30am today (Thursday 14 August 2025),

She was charged with manslaughter, and reckless grievous bodily harm.

The woman was refused bail to appear before Bail Division Court 2 today.

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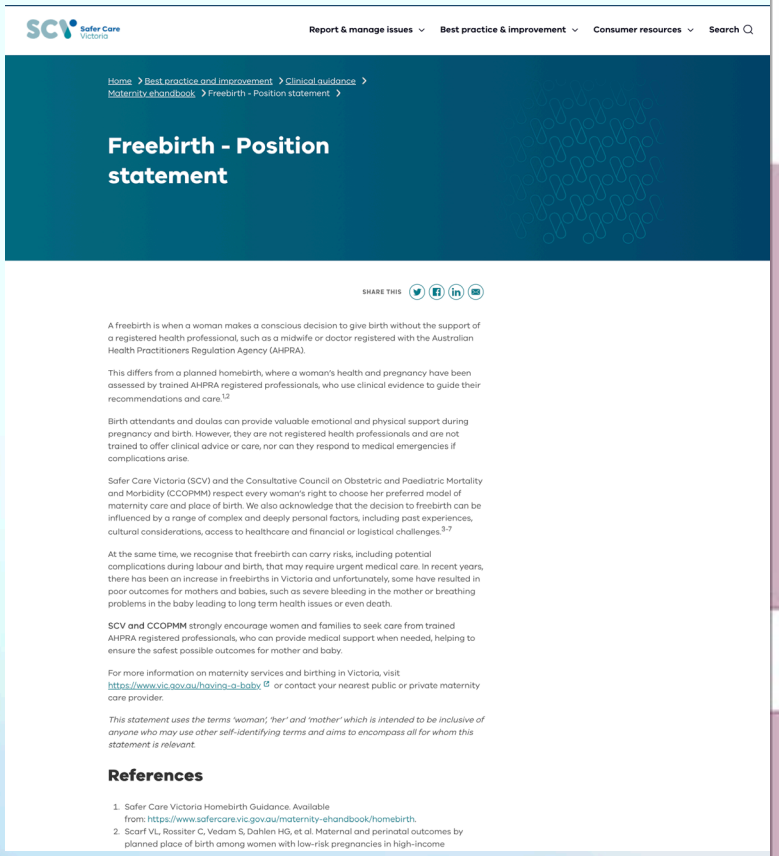
Latest News



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Freebirth - Position statement

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A freebirth is when a woman makes a conscious decision to give birth without the support of a registered health professional, such as a midwife or doctor registered with the Australian Health Practitioners Regulation Agency (AHPRA).

This differs from a planned homebirth, where a woman's health and pregnancy have been assessed by trained AHPRA registered professionals, who use clinical evidence to guide their recommendations and care.[1,2]

Birth attendants and doulas can provide valuable emotional and physical support during pregnancy and birth. However, they are not registered health professionals and are not trained to offer clinical advice or care, nor can they respond to medical emergencies if complications arise.

Safer Care Victoria (SCV) and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) respect every woman's right to choose her preferred model of maternity care and place of birth. We also acknowledge that the decision to freebirth can be influenced by a range of complex and deeply personal factors, including past experiences, cultural considerations, access to healthcare and financial or logistical challenges.[3-7]

At the same time, we recognise that freebirth can carry risks, including potential complications during labour and birth, that may require urgent medical care. In recent years, there has been an increase in freebirths in Victoria and unfortunately, some have resulted in poor outcomes for mothers and babies, such as severe bleeding in the mother or breathing problems in the baby leading to long term health issues or even death.

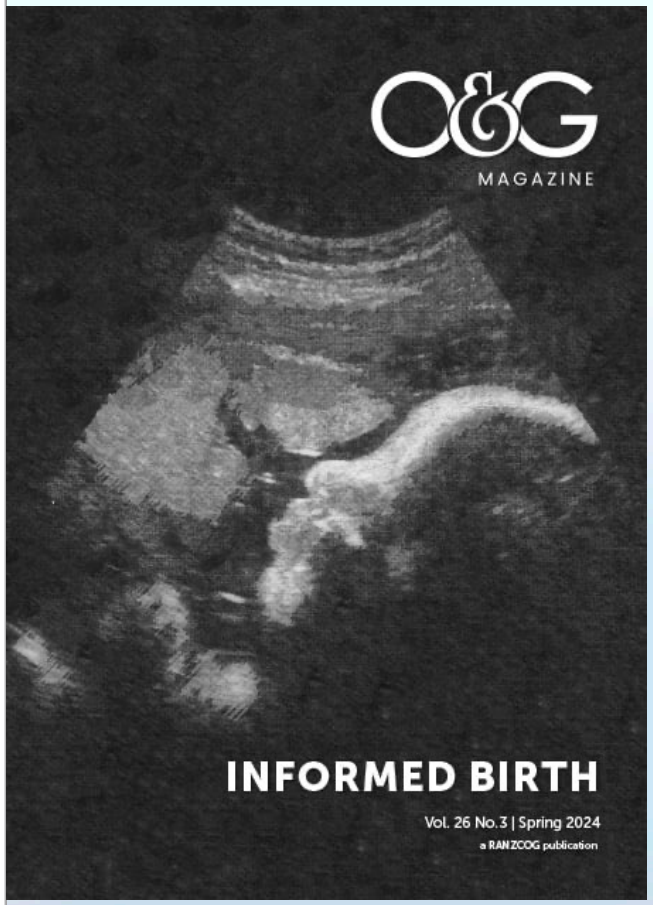
SCV and CCOPMM strongly encourage women and families to seek care from trained AHPRA registered professionals, who can provide medical support when needed, helping to ensure the safest possible outcomes for mother and baby.

For more information on maternity services and birthing in Victoria, visit https://www.vic.gov.au/having-a-baby or contact your nearest public or private maternity care provider.

This statement uses the terms 'woman', 'her' and 'mother' which is intended to be inclusive of anyone who may use other self-identifying terms and aims to encompass all for whom this statement is relevant.

References

1. Safer Care Victoria Homebirth Guidance. Available from: https://www.safercare.vic.gov.au/maternity-ehandbook/homebirth.
2. Scarf VL, Rossiter C, Vedam S, Dahlen HG, et al. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income





Birth Trauma

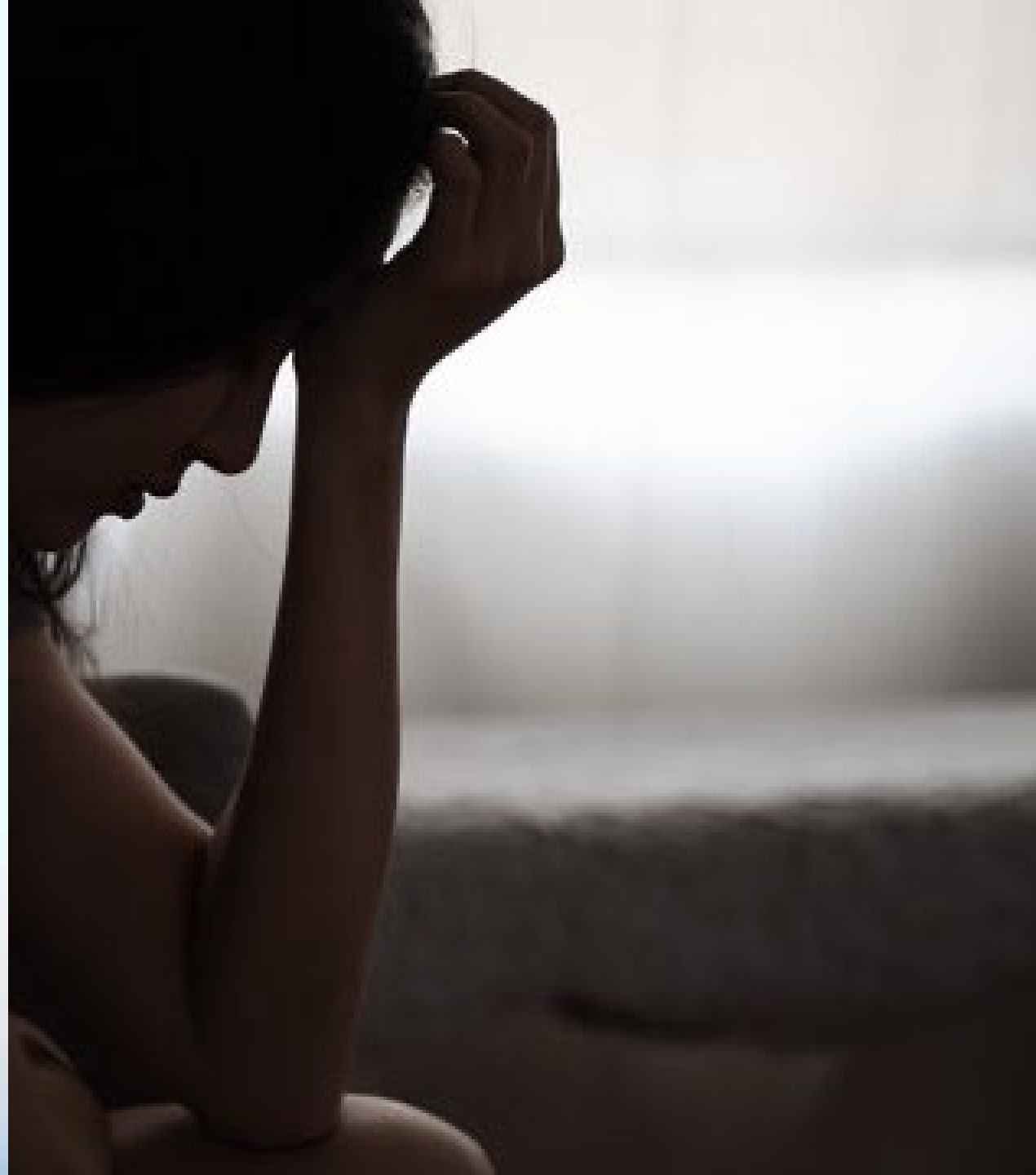
“A traumatic childbirth experience refers to a woman's

experience of interactions and/or events directly related to

childbirth that caused overwhelming distressing emotions and

reactions, leading to short and/or long-term negative impacts on

a woman's health and wellbeing.” (Leinweber et al., 2022, p. 687)



Incidence

- Experienced as traumatic with short- or long-term consequences ~ 33% (Keedle 2023)
- DP/MHW birth trauma study 28% of women self disclosure previous negative/traumatic birth and current fear of birth
- Childbirth-related post traumatic stress disorder (CB-PTSD) diagnosed on criteria
  - ~ 4.5% (Heyne et al., 2022)
  - ~12% in high-risk women (Heyne et al., 2022)
    - At risk for CB PTSD: pre-existing mental ill health, previous PTSD diagnosis, sexual abuse, poor social support, low socioeconomic status

Who is at risk?

- Aboriginal and Torres Strait Islander (esp. not being able to birth on Country) [1, 10]
- Young people (<24yrs) [1, 10]
- From multicultural communities [10]
- Of diverse genders/sexes and sexualities [10]
- Living in regional/rural/remote communities [10]
- Those with a history of trauma (childhood, sexual or previous birth trauma) [15]
- Those who have had a difficult pregnancy [7]
- Those who hold an intense fear of birthing [7]
- Link between emergency caesarean/induction and birth trauma [10, 15]
  - 1 in 10 women may develop PTSD following an emergency CS [6]
- Experience during labour:
  - Perception of being abandoned/unsupported [9,10]
  - Intensity of pain [10]
  - Fear of losing their life[10]
  - Fear of losing the life of their baby [10]
  - Fear of a partner losing their life (witnessing a PPH is very traumatic for partners) [10]

Manifestations

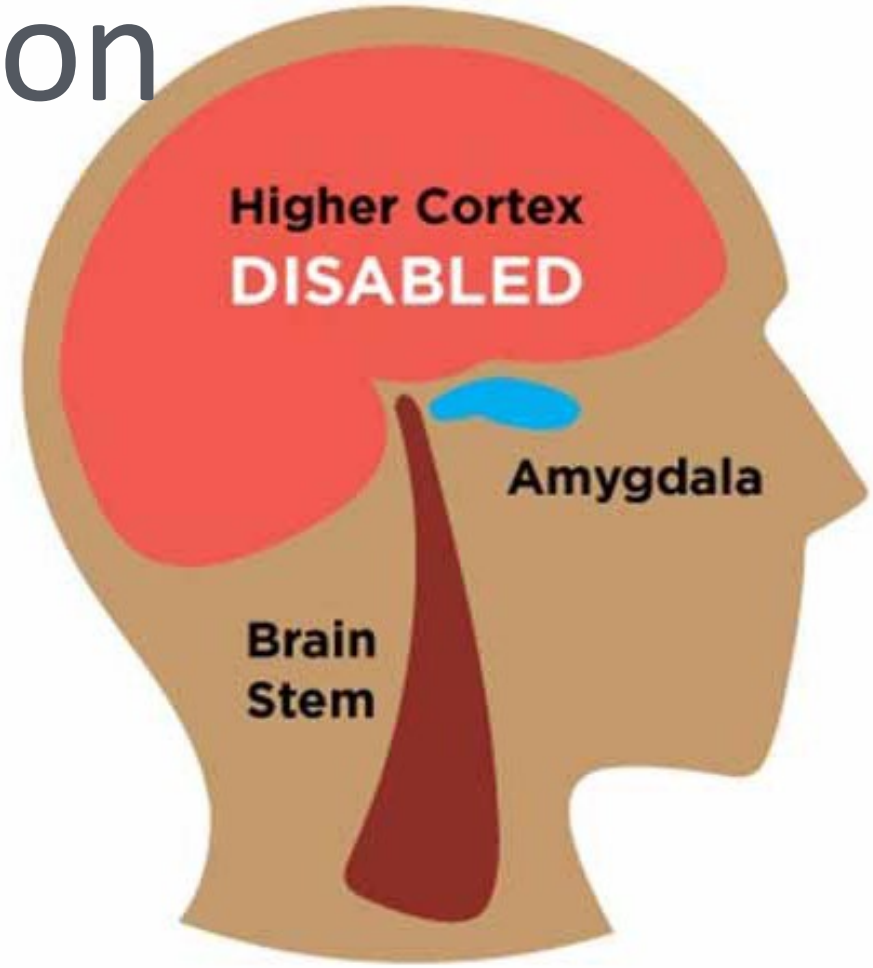
- Physical Symptoms: Ongoing health issues related to physical trauma. Persistent pain, fatigue, and a sense of physical fragility
- Emotional Symptoms: Feelings of fear, sadness, anger, or guilt, feeling disconnected from their baby, feelings of failure or inadequacy.
- Mental Health Symptoms: Symptoms of anxiety, depression, or Post Traumatic Stress Disorder (PTSD), difficulties with memory and concentration.
- Behavioural Symptoms: Avoidance of reminders of the birth, such as hospitals or even discussions about childbirth. Some may also avoid bonding activities with their baby due to fear or anxiety.

Birth trauma consequences

- Contribute to difficulties with bonding and breastfeeding [12, 13]
- Disrupt relationships [4, 5, 15]
- Affect employment [4, 5, 15]
- Lead to self-harm and suicide [4, 5, 15]
- Impact future pregnancy and birth decision making [4, 5, 15]
- Intergenerational impacts
  - PTSD may undermine a parents availability for sensitive and attuned caring, and impact their child's sense of secure attachment [13, 15]
- Implications on the health system.
- 1/3 midwives are affected by birth-related trauma [11]
- Birth trauma can lead people to refusing recommended care in subsequent pregnancies and contribute to increasing clinical risk

Birth Trauma Prevention

- Research suggests that a the most important factor in whether a birth is experienced as traumatic, is the quality of interactions with healthcare providers [4,10]
- Maternity care providers can work prior to birth, during labour and birth and after birth, to support emotional wellbeing, agency and autonomy, and recovery of birthing women
- Understanding of the physiological mechanism of why trauma occurs
  - If a woman doesn't feel safe, she is 'pre-loaded' to experience her birth as traumatic
  - Always assume you are speaking to the amygdala, so keep your language calm, reassuring AND stay connected at eye level.
  - Do not speak fast AND do not use jargon
- Feeling safe and cared for is protective
- Trauma-informed care for EVERYONE- Assume EVERYONE is vulnerable
- Validation of feelings helps people process and feel more 'normal'



Is debriefing useful?

"Every parent should be given an opportunity to debrief their birth experience, and to access additional support if this is needed, regardless of the events of the labour and birth (PANDA)"

- Cochrane review: There is little or no evidence to support either a positive or adverse effect of psychological debriefing for the prevention of psychological trauma in women following childbirth [2]
- 62% of women who experienced birth trauma reported wanting an opportunity to discuss in detail what had happened [9]
- BESt Study: women value debriefing and that it would become standard practice with maternity clinicians trained to provide this aspect of postnatal care. [3]
- The level of postnatal support offered to women following a perceived traumatic birth can impact on whether a woman goes on to develop ongoing distressing reflections on her birthing experience [8]

Debriefing tips

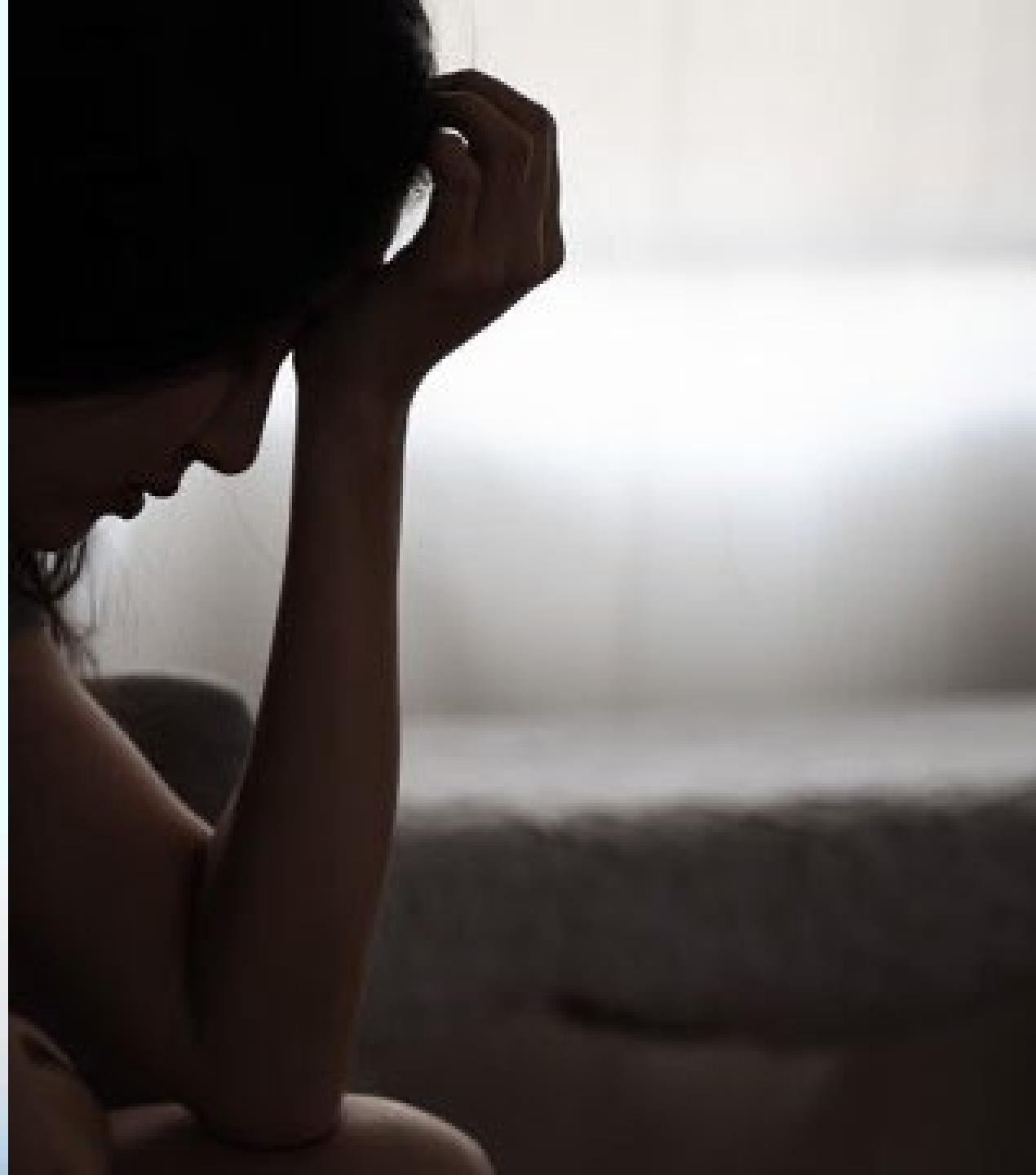
- An opportunity for patients to clarify the details of their birth, ask questions and to make sense of what happened
- Debrief starts immediately after birth
- Debrief is everyone's job
- It should be patient-led
  - Open the conversation generally, eg) *"How was your experience of labour/birth"*
    - Structure is variable: "What everyone needs from these conversations is different , I'm happy to be guided by you"
- Active listening is more important than talking.
- Offer validation
- A sense of emotional safety is key
- It is NOT trauma counselling

Identifying women who need onward referral

Questions to open a conversation:

- "Since giving birth/since your partner gave birth, have you experienced any of the following?
  - Distressing memories and thoughts about your birth experience?
  - Sleep changes like insomnia or nightmares?
  - Appetite changes?
  - Irritability or frustration, or feelings of being on edge?
  - Difficulty engaging in caregiving tasks?
  - An increased use of alcohol or substances?
  - Self harm or suicidal thoughts?

- PTSD key criteria
  - Intrusion: distressing memories, flashbacks, nightmares
  - Arousal: a heightened and persistent sense of worry or concern, usually around the health/safety of baby
  - Avoidance: obvious like avoiding the hospital. More subtle like a sense of numbness of disconnection from routine or loved ones
  - Lowered mood: loss of enjoyment in life, sense of hopelessness



Postnatal pathways

Mercy Hospital for Women

•Debrief clinic: Patients with an obstetric complexity or traumatic birth should be offered debrief on the ward first by the reg +/- senior reg +/- consultant. If Debrief Clinic appropriate, please ensure the patient wants the appointment and understands what it is for.

•Patients with acute distress/ anxiety/ depression: Inpatient referral to CLN +/- PNMH. Community bases service referral once discharged.

•Perinatal loss- Referral to STAR clinic

•Other Perinatal Patients- will be reviewed in the clinic that they were being seen in, usually by the Consultant that has provided them with most of their care.

•Third/ Fourth Degree Tears- referral to Gynae Clinic and Physiotherapy

•MGP patients: Debriefing will be undertaken by the midwife known to the patient. Referral to Debrief Clinic is sometimes appropriate after this.

•SAGE: Referral back to SAGE clinic

•Patients with complaints: Refer to the Feedback Team. Complaints are best handled outside of the Debrief Clinic. Sometimes a patient ends up having both once we've explored their concerns through the feedback process.

Challenges to providing an Obstetric Debrief Service

- Accurate identification of patients in need of an appointment- Birth experience survey for all women as part of the OVBB
- Patients not understanding what the appointment is for
  - Written patient information, preparation for appointment
- High FTA rate - better identification of those in need, debriefing on the ward, more senior oversight of referrals, better support of junior staff seeing women postnatally
- Identifying care delivery problems and capturing actions for QI- honouring women's voices and experiences
  - Referral to APSE committee
  - Referral to feedback team- MD feedback meeting with patient
- Debriefing the debrief meeting

Partnering with Women Who Decline Recommended Maternity Care Clinical Guideline

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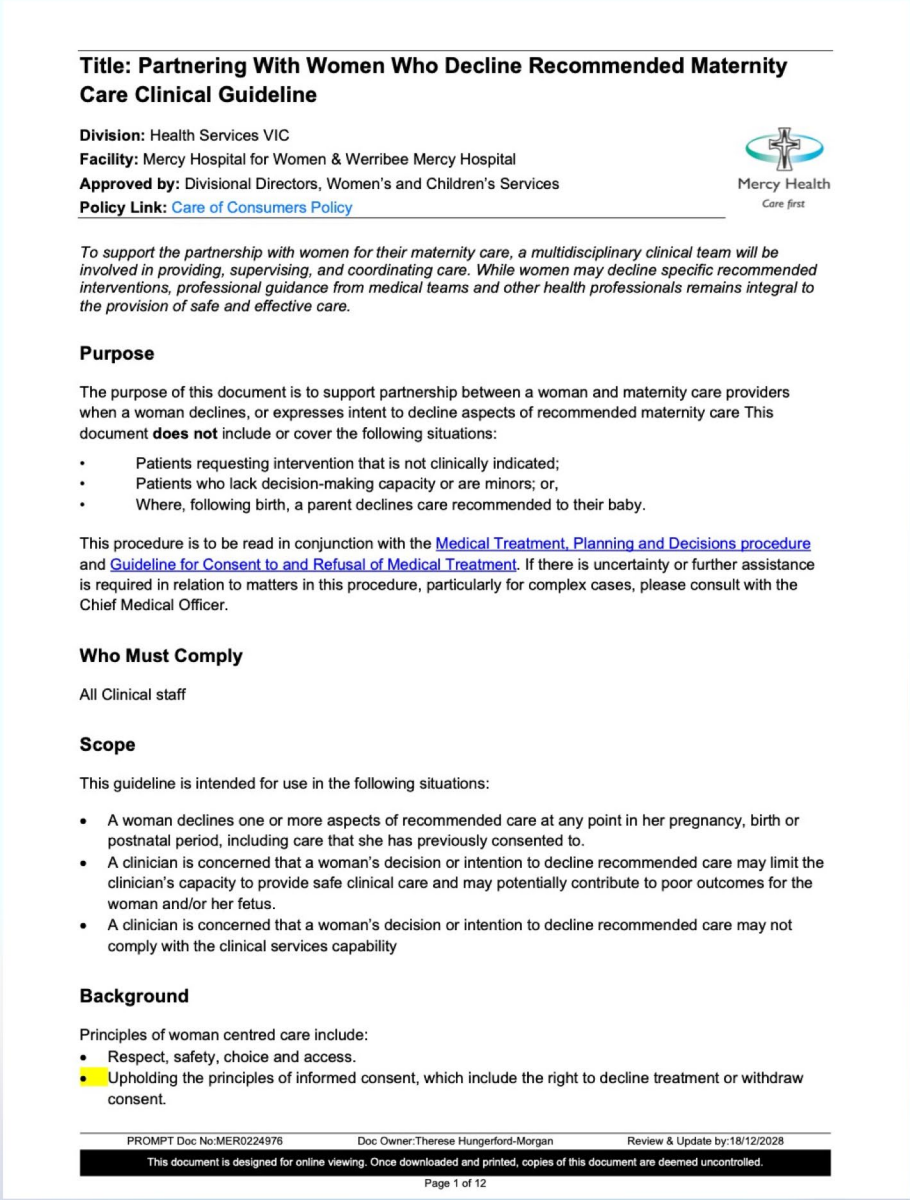

Title: Partnering With Women Who Decline Recommended Maternity Care Clinical Guideline

Division: Health Services VIC
Facility: Mercy Hospital for Women & Werribee Mercy Hospital
Approved by: Divisional Directors, Women's and Children's Services
Policy Link: Care of Consumers Policy

Mercy Health
Care first

To support the partnership with women for their maternity care, a multidisciplinary clinical team will be involved in providing, supervising, and coordinating care. While women may decline specific recommended interventions, professional guidance from medical teams and other health professionals remains integral to the provision of safe and effective care.

Purpose

The purpose of this document is to support partnership between a woman and maternity care providers when a woman declines, or expresses intent to decline aspects of recommended maternity care This document **does not** include or cover the following situations:

- Patients requesting intervention that is not clinically indicated;
- Patients who lack decision-making capacity or are minors; or,
- Where, following birth, a parent declines care recommended to their baby.

This procedure is to be read in conjunction with the Medical Treatment, Planning and Decisions procedure and Guideline for Consent to and Refusal of Medical Treatment. If there is uncertainty or further assistance is required in relation to matters in this procedure, particularly for complex cases, please consult with the Chief Medical Officer.

Who Must Comply

All Clinical staff

Scope

This guideline is intended for use in the following situations:

- A woman declines one or more aspects of recommended care at any point in her pregnancy, birth or postnatal period, including care that she has previously consented to.
- A clinician is concerned that a woman's decision or intention to decline recommended care may limit the clinician's capacity to provide safe clinical care and may potentially contribute to poor outcomes for the woman and/or her fetus.
- A clinician is concerned that a woman's decision or intention to decline recommended care may not comply with the clinical services capability

Background

Principles of woman centred care include:

- Respect, safety, choice and access.
- Upholding the principles of informed consent, which include the right to decline treatment or withdraw consent.

PROMPT Doc No:MER0224976 Doc Owner:Therese Hungerford-Morgan Review & Update by:18/12/2028

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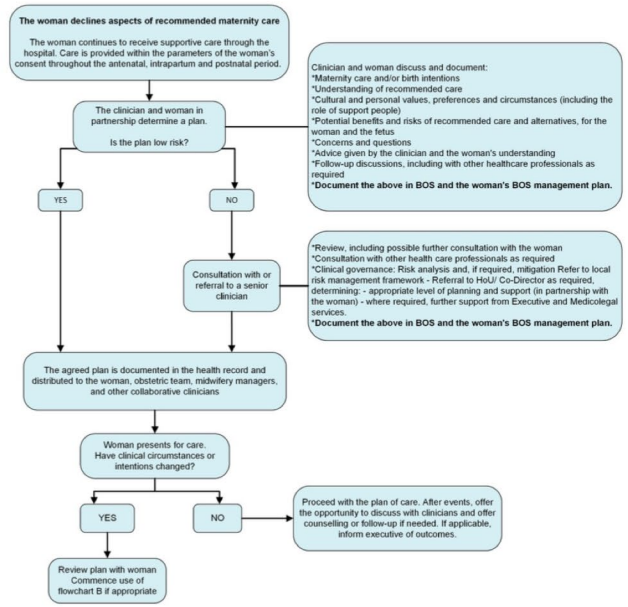
Page 1 of 12

Appendix A

Flowcart A. Partnering with the woman who declines recommended maternity care: antenatal



If the woman declines recommended care for the first time in labour, refer to flowchart B.

Title: Partnering With Women Who Decline Recommended Maternity Care Clinical Guideline

Division: Health Services VIC
Facility: Mercy Hospital for Women & Werribee Mercy Hospital
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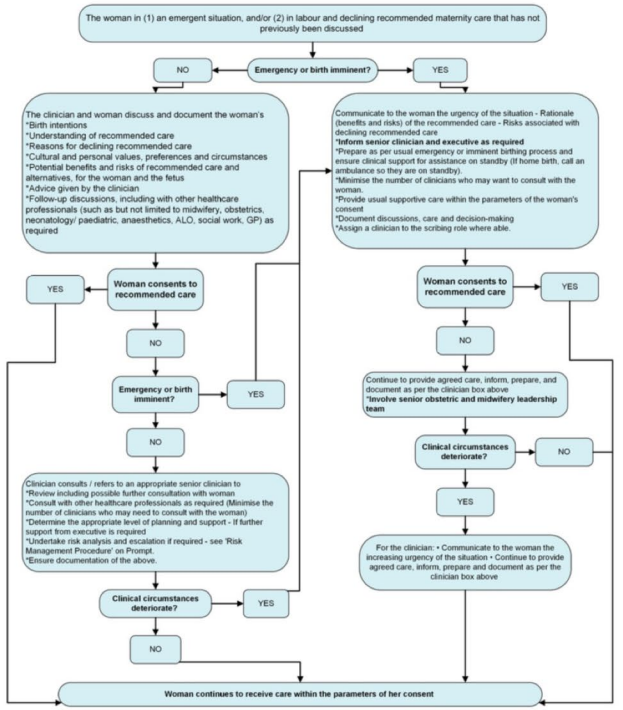
Flowchart B. Partnering with the woman who declines previously undiscussed recommended maternity care in an emergent situation or during labour



Title: Partnering With Women Who Decline Recommended Maternity Care Clinical Guideline

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Appendix C – Communication checklist for informed refusal process

☐	Checklist	Tips/Comments
	An appropriate clinician is undertaking the informed declining of care process	If there is a likely consequence of death or severe harm, the Consultant Obstetrician must lead the discussion.
	Cultural safety of the woman and her support person is considered	Consider risk and safety within social, emotional, cultural and financial contexts, as well as the bio-medical context. Use an interpreter and/or cultural support worker where applicable.
	Assessment of decision-making capacity of the woman to refuse recommended care is undertaken	
	Reasons for declining care are explored and well-identified, where possible	
	The recommended care being offered is described	
	Reasons the recommended care is being offered are explained	*Refer to national and professional evidence-based resources, such as:* RANZCOG - Statements and guidelines directory Australian Commission on Safety and Quality in Health Care - Stillbirth Clinical Care Standard The Centre of Research Excellence in Stillbirth Australian College of Midwives - National Midwifery Guidelines for Consultation and Referral RANZCOG - Maternity Care in Australia RANZCOG - Home Births
	Potential benefits and risks of the recommended care are explained	Communicate risks and benefits using absolute (rather than relative) values, for example: discuss risk increasing from "1 in 100" to "2 in 100", rather than "risk doubling".
	Where there are appropriate alternatives for the recommended care, these are discussed and explained, including the risks and consequences of the appropriate alternatives	
	Risks and consequences of declining the recommended care are explained	
	Opportunity is provided for the woman and support person to ask questions	
	After confirming the understanding of the woman, the declining of recommended care is verbally obtained from the woman and acknowledged by the clinician. The woman is informed that she can modify or withdraw the decline of recommended care at any stage.	A copy of the documentation of the patient's informed refusal is to be given to the patient, where practicable and when the decision about declining of recommended care is made in the antenatal period. A copy of the patient information sheet is to be given to the patient.
	The maternity care plan is discussed and updated based on the woman's wishes and preferences, and discussion about declining of recommended care.	

Recommended maternity care- it's your decision

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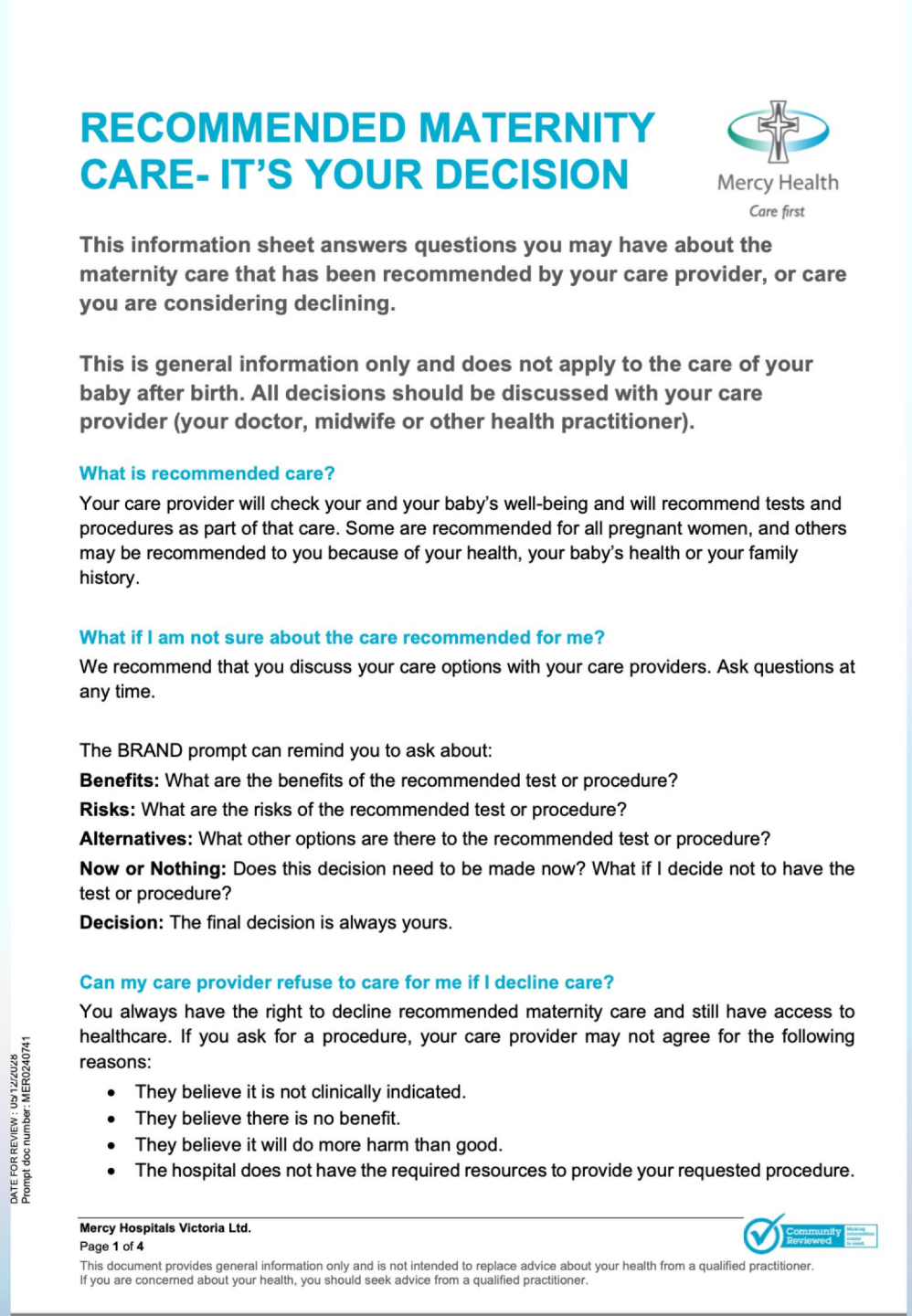

RECOMMENDED MATERNITY CARE- IT'S YOUR DECISION

Mercy Health
Care first

This information sheet answers questions you may have about the maternity care that has been recommended by your care provider, or care you are considering declining.

This is general information only and does not apply to the care of your baby after birth. All decisions should be discussed with your care provider (your doctor, midwife or other health practitioner).

What is recommended care?

Your care provider will check your and your baby's well-being and will recommend tests and procedures as part of that care. Some are recommended for all pregnant women, and others may be recommended to you because of your health, your baby's health or your family history.

What if I am not sure about the care recommended for me?

We recommend that you discuss your care options with your care providers. Ask questions at any time.

The BRAND prompt can remind you to ask about:

Benefits: What are the benefits of the recommended test or procedure?

Risks: What are the risks of the recommended test or procedure?

Alternatives: What other options are there to the recommended test or procedure?

Now or Nothing: Does this decision need to be made now? What if I decide not to have the test or procedure?

Decision: The final decision is always yours.

Can my care provider refuse to care for me if I decline care?

You always have the right to decline recommended maternity care and still have access to healthcare. If you ask for a procedure, your care provider may not agree for the following reasons:

- They believe it is not clinically indicated.
- They believe there is no benefit.
- They believe it will do more harm than good.
- The hospital does not have the required resources to provide your requested procedure.

DATE FOR REVIEW : 03/12/2028
Prompt doc number: MER0240741

Community Reviewed

Key principles

Partnering with women

- First do no harm: Respect for autonomy and informed consent
- Self awareness of cognitive biases influencing care
- Engagement of the most senior member of staff available
- Rediscussion with clinical evolution and change in risk

Document, document, document

And Communicate, Communicate, Communicate

- **Each** discussion
  - That the woman has decision making capacity
  - That recommended care is being declined
  - The potential risks of declining care
  - The potential benefits and risks of the recommended care
  - That the woman has been given opportunity to ask questions
  - That an interpreter and/ or cultural support worker was involved where appropriate
  - The persons present for the discussion
- Communicate with other health care professionals as required
  - Escalate within the team- seek MUM, AMUM, Consultant input
  - When patients disengage from care- GPs, Homebirth Midwives, other care providers

Self awareness of cognitive biases influencing care

- Systematic review: "Therapeutic Illusion"
  - Most physicians overestimated benefit and underestimated harm
  - Over-optimism has the potential to push physicians to offer, and patients to accept, more interventions than might be necessary or desirable
- Other factors: Past (recent) experience (good and bad), clinician tolerance for risk, easier to do something than do nothing, fear of malpractice, reliance on relative risk rather than absolute risk.
- Beware coercion
  - Magnifying risk estimates to dissuade a patient from an option
  - Exaggerating benefits or withholding risks of a recommended treatment
  - Demeaning a woman for putting her fetus at risk
  - Threatening to withdraw care if a woman refuses recommended care

JAMA Internal Medicine | Review | LESS IS MORE

Clinicians' Expectations of the Benefits and Harms of Treatments, Screening, and Tests
A Systematic Review

Tammy C. Hoffmann, PhD; Chris Del Mar, MD, FRACGP

IMPORTANCE Inaccurate clinician expectations of the benefits and harms of interventions can profoundly influence decision making and may be contributing to increasing intervention overuse.

OBJECTIVE To systematically review all studies that have quantitatively assessed clinicians' expectations of the benefits and/or harms of any treatment, test, or screening test.

EVIDENCE REVIEW A comprehensive search strategy of 4 databases (MEDLINE, EMBASE, Cumulative Index of Nursing and Allied Health Literature, and PsycINFO) from the start years to March 17-20, 2015, with no language or study type restriction, was performed. Searches were also conducted on cited references of the included studies, and experts and study authors were contacted. Two researchers independently evaluated methodologic quality and extracted participants' estimates of benefit and harms and authors' contemporaneous estimates.

FINDINGS Of the 8166 records screened, 48 articles (13 011 clinicians) were eligible. Twenty studies focused on treatment, 20 on medical imaging, and 8 on screening. Of the 48 studies, 30 (67%) assessed only harm expectations, 9 (20%) evaluated only benefit expectations, and 6 (13%) assessed both benefit and harm expectations. Among the studies comparing benefit expectations with a correct answer (total of 28 outcomes), most participants provided correct estimation for only 3 outcomes (11%). Of the studies comparing expectations of harm with a correct answer (total of 69 outcomes), a majority of participants correctly estimated harm for 9 outcomes (13%). Where overestimation or underestimation data were provided, most participants overestimated benefit for 7 (32%) and underestimated benefit for 2 (9%) of the 22 outcomes, and underestimated harm for 20 (34%) and overestimated harm for 3 (5%) of the 58 outcomes.

CONCLUSIONS AND RELEVANCE Clinicians rarely had accurate expectations of benefits or harms, with inaccuracies in both directions. However, clinicians more often underestimated rather than overestimated harms and overestimated rather than underestimated benefits. Inaccurate perceptions about the benefits and harms of interventions are likely to result in suboptimal clinical management choices.

Supplemental content

CME Quiz at jamanetworkcme.com

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JAMA Intern Med. 2017;177(3):407-419. doi:10.1001/jamainternmed.2016.8254
Published online January 9, 2017.

Senior involvement

- Involve the most senior available clinician from the outset to avoid multiple conversations and climbing up the seniority ladder
- Valid Consent: Refusal of recommended treatment does not have to be informed. The woman has a right to refuse discussion about the risks and benefits of her decision to refuse recommended care
- Any refusal to undertake counselling by medical staff must be made directly to the senior obstetric registrar or consultant. It is not sufficient for this to be conveyed to medical staff by other team members or patient support people

Re-discussion with clinical evolution

- The patient is able to change her decision or withdraw previously given consent at any time
- Discuss all changes in clinical circumstances with the patient
- Provide updated recommendations based on the clinical situation

Quintuple aim

- Improving patient experience
- Improving population health
- Keep staff physically and psychologically safe
- Provide value for money care
- Ensure equitable access

Patient centred care

- Antenatal education- induction, caesarean, general education and expectation setting
- Expansion of MGP program- continuity
- Continuity of care for Red and Yellow risk patients- booking all appointments through
- Water births
- Home birth program
- Feedback department
- OVBB and patient experience surveys



Further learning

- PANDA + Birth Trauma Australia: Understanding birth-related trauma
  - A free 30-min course
  - https://learning.panda.org.au/external/catalogue/preview/course/55?tenancyId=2&fbclid=IwY2xjawMN78NleHRuA2FlbQIxMABicmlkETFUcmZMZkxJYzNhckRKUE9UAR4Bi5gXSXlniq_LffnlpmlUSbUrPR3aDYymy_QJc9I2GNJ7g8SpmsUXsXR7gQ_aem_X_a0KCny4-JGc0x526lu3g
- PANDA: "Perinatal Suicide: One Conversation Can Save a Life."
  - A Free 20-min course
  - https://learning.panda.org.au/external/catalogue/preview/course/46?tenancyId=2
- Birth Trauma Australia: Understanding Birth Trauma (CPD accredited, via ThinkNatal)
- https://birthtrauma.teachable.com/p/module-1-what-is-birth-related-trauma

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ANTENATAL ULTRASOUND

Dr Peter Jurcevic

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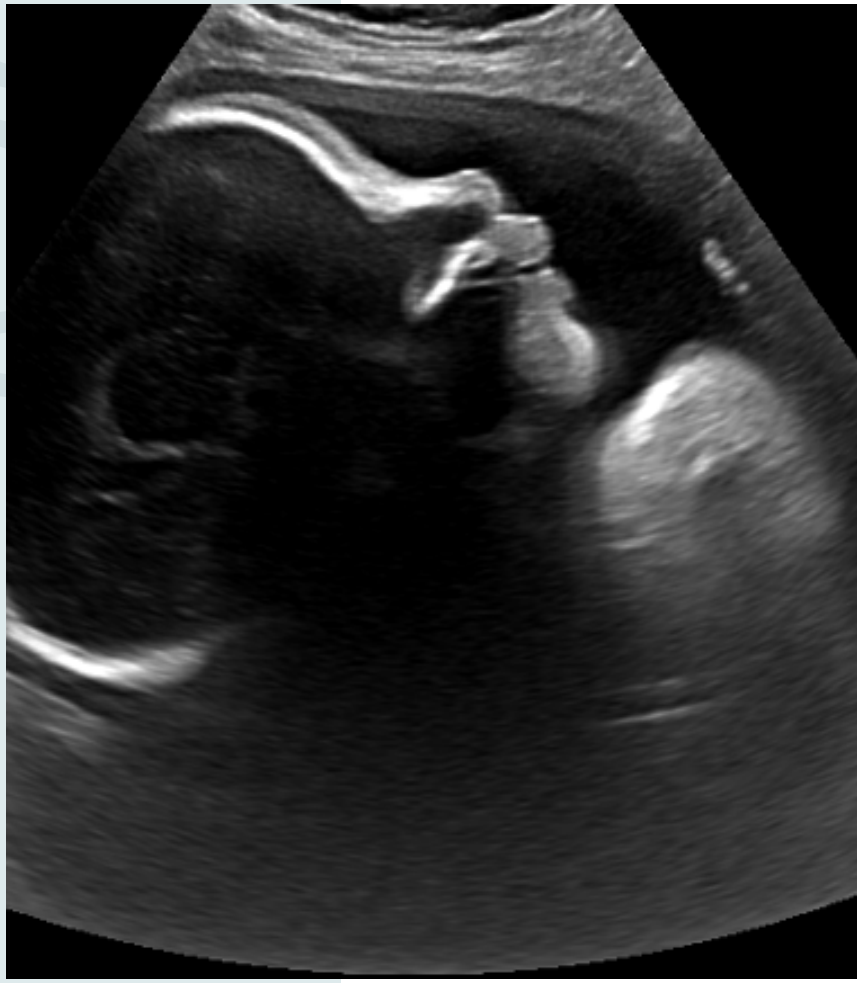


Figure 1 – Third Trimester Growth Scan
Image reproduced from Beam Radiology [1]

Agenda

- Role of Ultrasound in Pregnancy
- What is Normal?
- Variances
- Key Messages

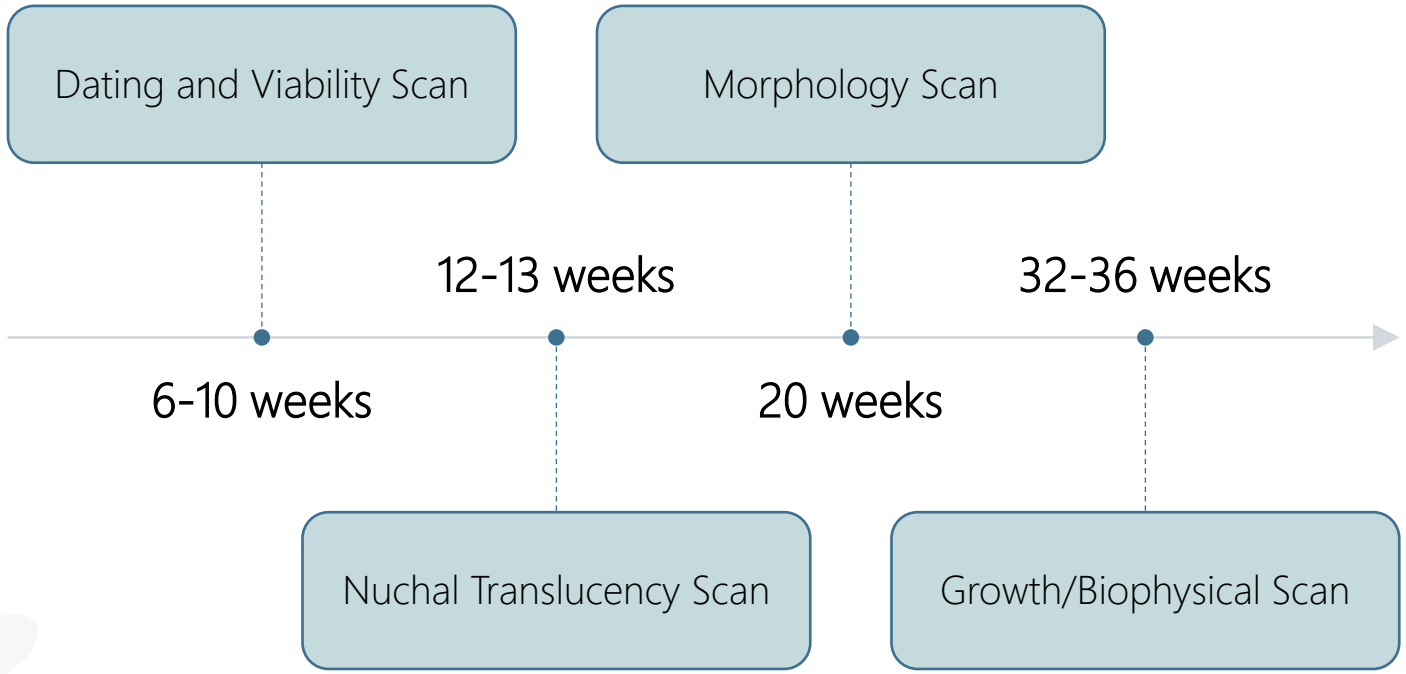
Role of Ultrasound in Pregnancy

Ultrasound technology is invaluable in pregnancy care, improving the assessment and management of:

- Early pregnancy viability
- Ectopic pregnancy
- Multiple pregnancies
- Fetal growth and wellbeing
- Fetal abnormalities (genetic and structural)
- Pre-eclampsia and preterm birth
- Invasive procedures

Routine Antenatal Ultrasounds

- GPs often have limited access to the resources needed to perform antenatal ultrasounds at frequent intervals, compared to obstetricians
- FRANZCOG guidelines recommend GPs order numerous ultrasound scans throughout the pregnancy



Dating and Viability Scans (6-10 weeks)

Assesses gestational age, as well as other factors like fetal heartbeat and number of fetuses

What is normal?

- Singleton pregnancy
- Visible yolk sac and fetal heart
- Regular gestational sac
- Long/closed cervix

What else can be assessed?

- Chorionicity in multiples
- Vanishing twins
- Potential adnexal pathology (e.g., ovarian cysts)

Dating and Viability Scans (6-10 weeks)

Common Variances

- Extra-chorionic clot is identified, regardless of whether the patient has experienced PV bleeding or not
- Fetal heartrate is seen but is <100bpm
- Fetal pole is measuring behind in dates according to LMP

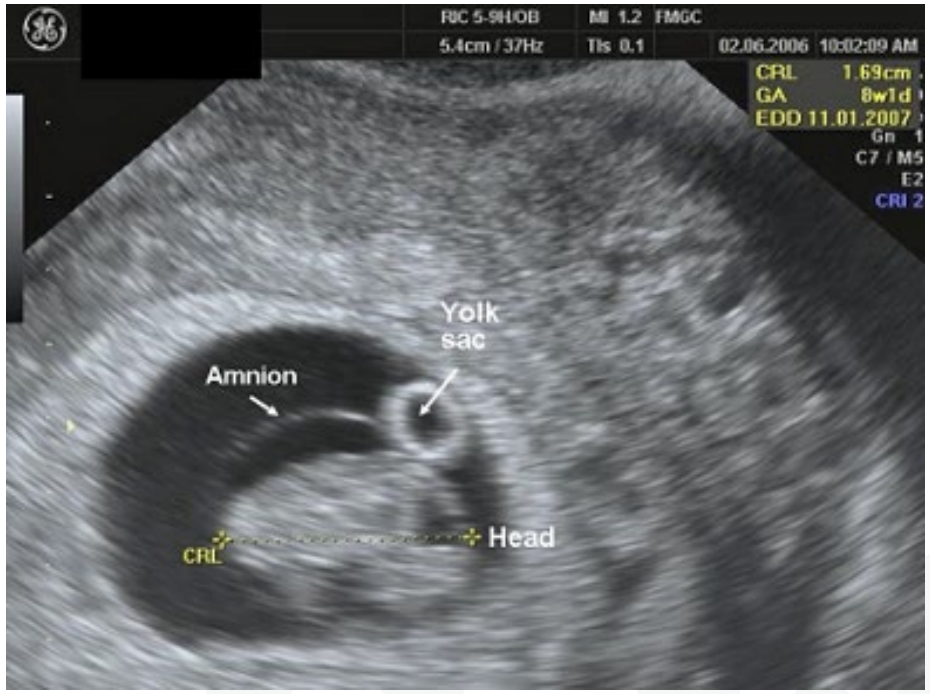


Figure 2 – 8 Week Dating Scan
Image reproduced from Fetal Medicine and Gynaecology Centre[2]

Nuchal Translucency Scan (12-13 weeks)

Assesses for chromosomal abnormalities and discernable structural defects.

What is normal?

- Nuchal thickness of <2.5mm
- Visible nasal bone
- Unremarkable cardiac/skeletal assessment
- Cervical length of >3cm

What else can be assessed?

- Uterine artery pulsatility (uPI), which can prognosticate pre-eclamptic and IUGR risk
- Elevated resistance ('notching') is usually reported on

Nuchal Translucency Scan (12-13 weeks)

Common Variances

- NT measurement >2.5mm, with normal NIPT
- NT measurement <2.5mm, normal fetal heart and CRL but no nasal bone is seen
- Raised uPI reading
- Cervical length <2.8cm, with no pressure change
- Elevated NT/MSS risk for T21, without NIPT

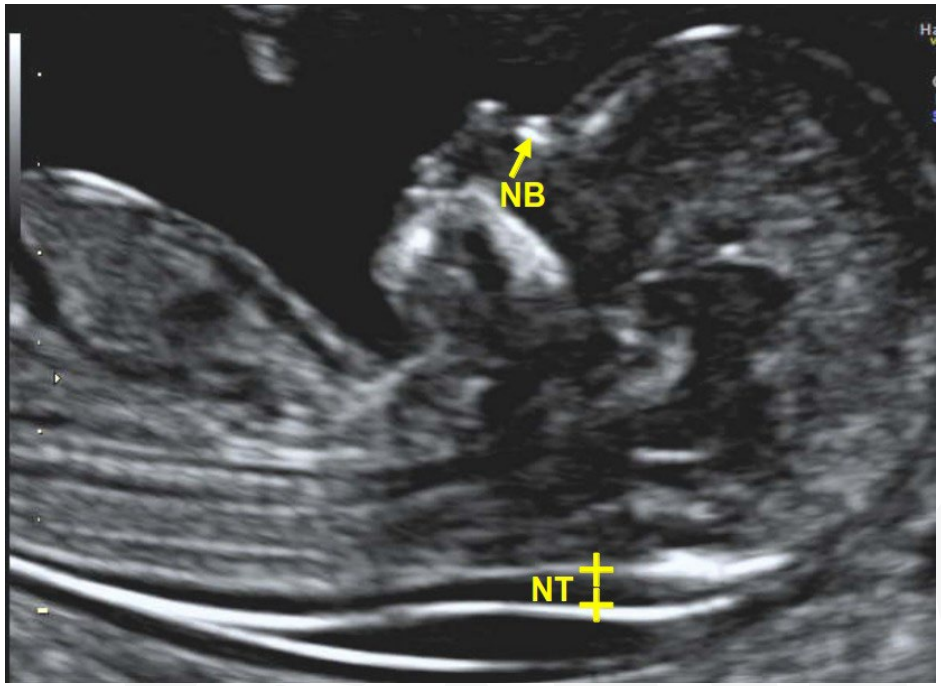


Figure 3 – Normal Nuchal Translucency
Image reproduced from The Fetal Medicine Foundation[3]

Morphology Scan (20 weeks)

Assesses mid-pregnancy fetal growth

What is normal?

- Well-located placenta and umbilical cord
- Fetal biometry aligning with dates
- Cervical length >2.5cm
- Sound amniotic fluid levels

What else can be assessed?

- Pressure-related cervical shortening and funnelling
- This can be a marker for prematurity risk (both cervical incompetence and TPL)

Morphology Scan (20 weeks)

Common Variances

- Choroid plexus
- Echogenic cardiac foci
- Borderline length of long bones
- Calcified bowel
- Normal cervical length with pressure change
- Placenta covering/adjacent to the cervical internal os

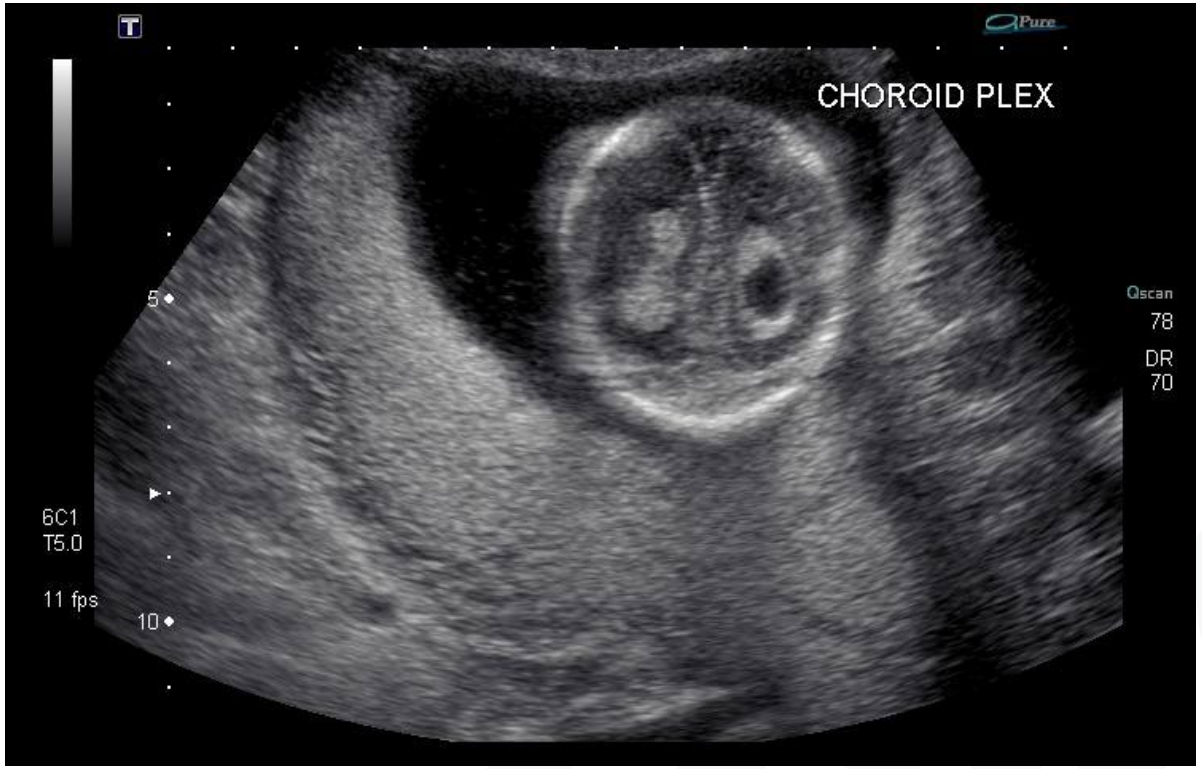


Figure 4 – Antenatal Choroid Plexus Cyst
Image reproduced from Radiopedia[4]

Morphology Scan – cont.

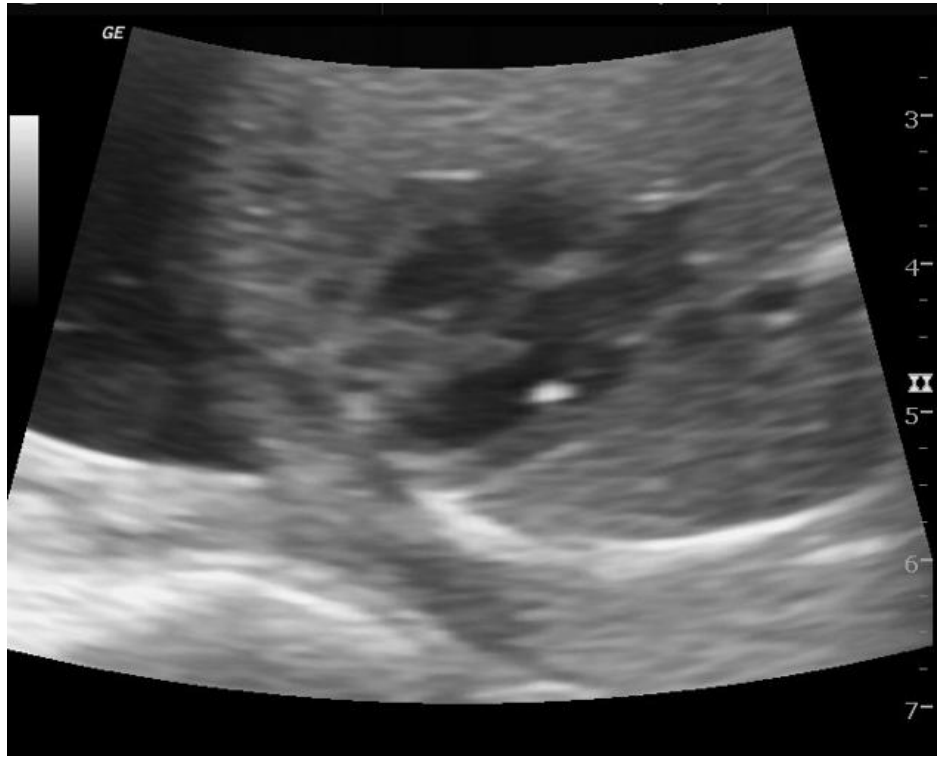


Figure 5 – Echogenic Left Ventricular Focus
Image reproduced from Radiopedia[5]

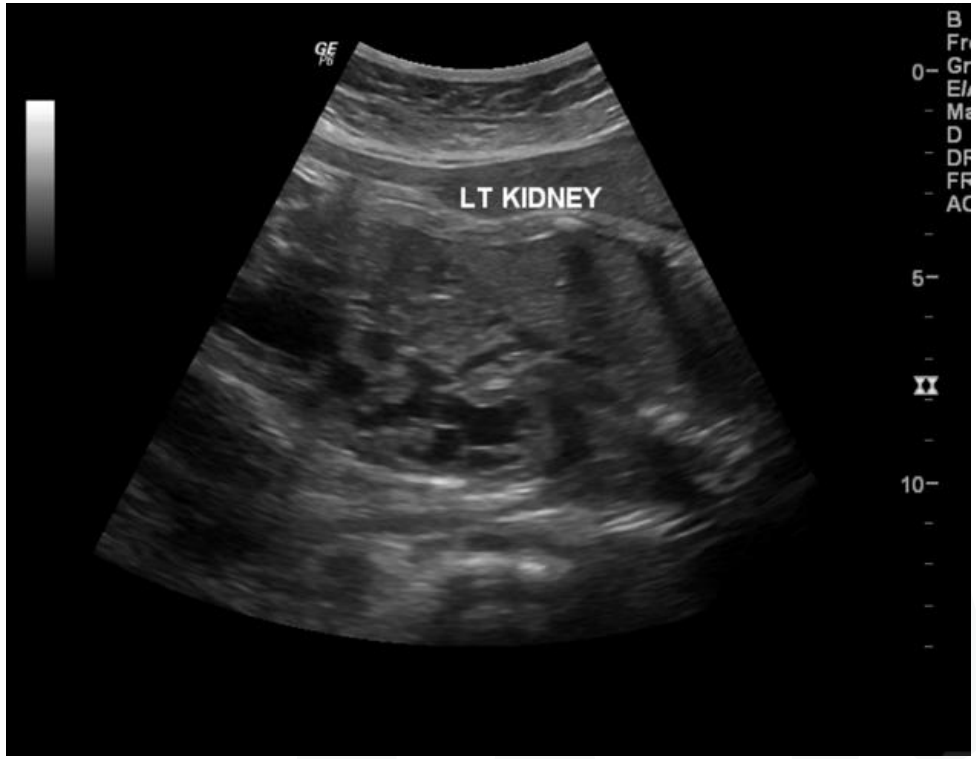


Figure 6 – Fetal Pyelectasis
Image reproduced from Radiopedia[6]

Growth/Biophysical Scan (32-36 weeks)

Optional third-trimester growth scan

What is normal?

Centile growth aligning with dates	Placental function and fetal wellbeing
• Estimated fetal weight • Fetal head size (BPD) • Fetal abdominal circumference • Fetal femur length	• Uterine artery pulsatility (SD ratio) • Middle cerebral artery • Amniotic fluid index • Ductus venosus

What else can be assessed?

- Previously-missed fetal anomaly (1 in 300)
- Acknowledge limitations of this scan due to focus on growth and placental function

Growth/Biophysical Scan (32-36 weeks)

Common Variances

- Placenta within 2cm of cervical internal os
- One concerning biophysical parameter, despite average fetal growth and movement

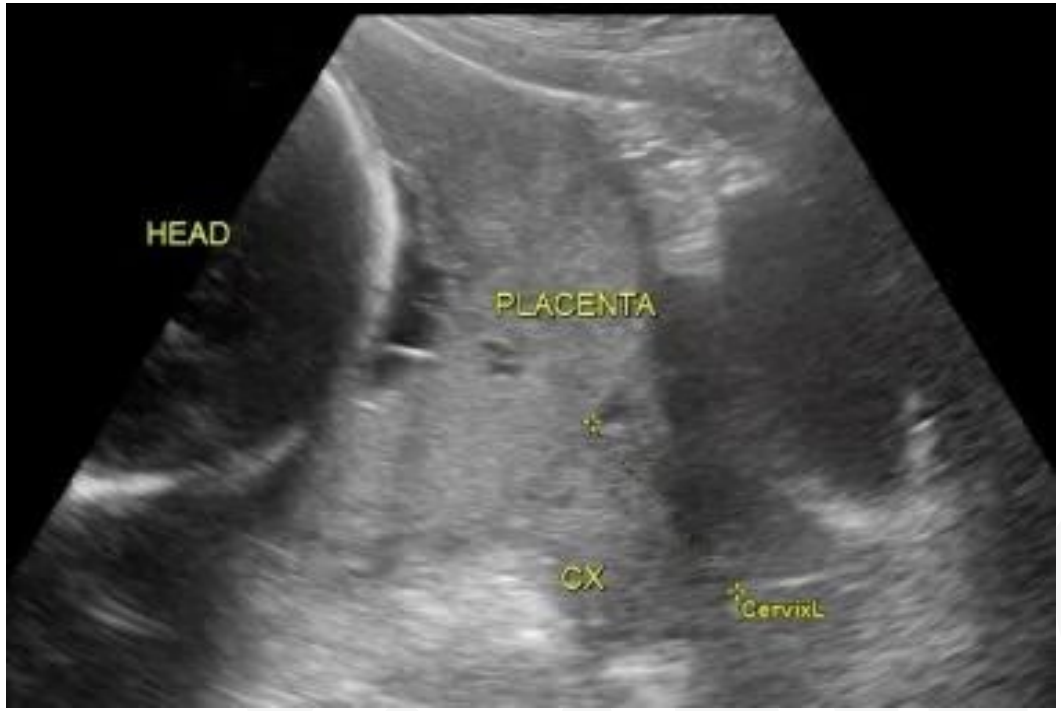


Figure 7 – Placenta Previa
Image reproduced from Medscape[7]

Key Message

When in doubt… REFER!

GP/LMO → Obstetrician or Tertiary Maternity Hospital

THANK YOU

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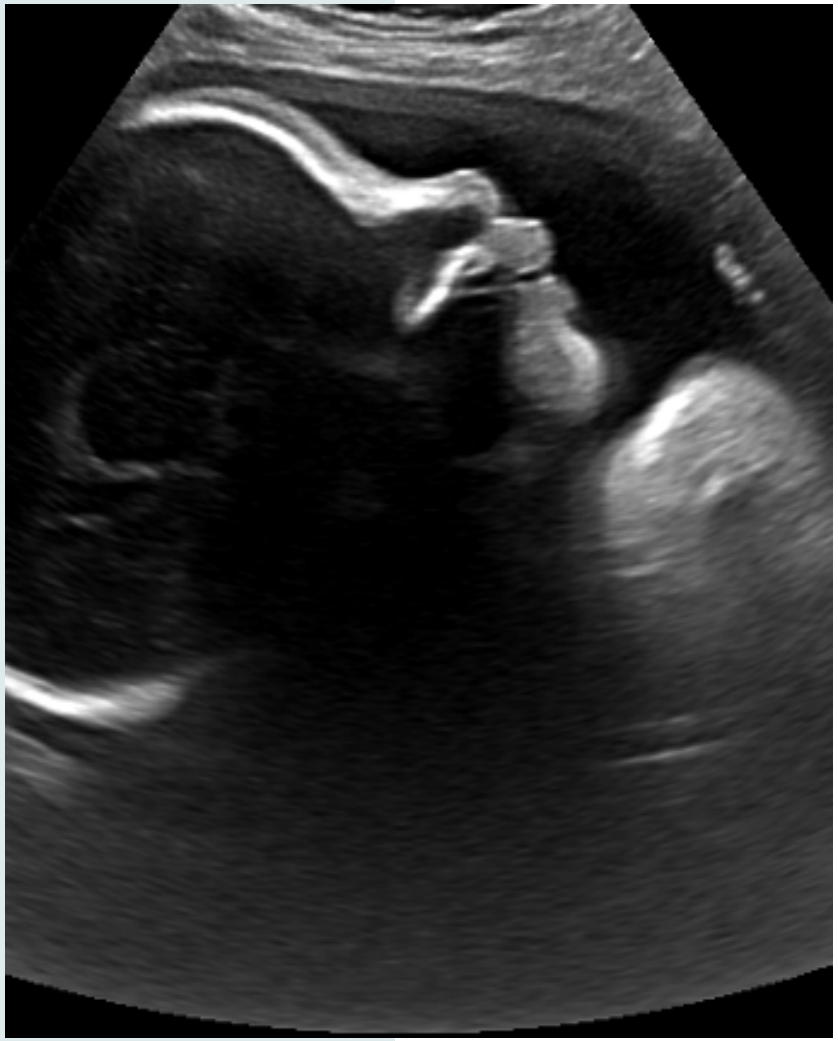

Figure 1 – Third Trimester Growth Scan
Image reproduced from Beam Radiology[1]

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Session Conclusion

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