



Position Statement On Small Unit Rural Obstetrics

February 2002

1. **MAIN STATEMENT** (The material is fully referenced in the second section.)

The persistent tendency for smaller rural obstetric units to close in Victoria is a significant component of rural rundown. There were over 40 of 123 unit closures in the years 1983 to 1997⁽¹⁾. Safe confinement facilities close to home are an essential component of viable Australian rural community and economy. Rural viability requires minimum disruption to family life and rural industry. The prime objective of a healthy mother and baby must be met by the safest possible obstetric system. Repeated studies have shown small rural units, however small to have **substantially better outcomes** and are cheaper per confinement than metropolitan or provincial units. The corollary is that closure leads to increasing morbidity and mortality. *There is not and never has been any valid argument for closure of small rural obstetric units on grounds of safety or smallness.* The wishes of mothers must be respected and facilities provided.

There will be a supply of GP obstetricians. It is the avowed intention of The Australian College of Rural and Remote Medicine (ACRRM) and hence of Regional Rural GP Training programs established under General Practice Education and Training Ltd (GPETL) to train GPs with obstetric capabilities for the bush. In addition to the substantial core of remaining GP obstetricians, there continues to be a substantial supply of obstetrically experienced procedural GPs from overseas, especially South Africa. Within Australia, however, experienced GPs continue to haemorrhage⁽²⁾ from the workforce and in general do not resume obstetric practice, so that every effort has to be made in improving workforce retention. Examination for and maintenance of accreditation in Standards for GP Obstetrics are the responsibility of the Joint Consultative Committee for Obstetrics (RACOG, ACRRM and RACGP).

Recommendations of the RDAV – Safety in rural Obstetrics requires the following:

Recommendation 1. Good access.

Closer is better, but in excess of one hour is generally accepted as posing unacceptable risk. Where this is the case, the provision of accommodation at the referral centre is desirable as recommended in NSW⁽³⁾. Travel in labour is highly undesirable especially in multiparous mothers who should desirably spend the two weeks previous to the estimated date of delivery at the intended location of birth. The catastrophic decline in numbers of rural obstetric units has occurred because of planning through politics. There remains a strong case for reappraisal and the establishment of policy to provide units in selected locations, re-establishing where indicated.

Recommendation 2. Good capability.

- a. With continuing entry of GPs with a variety of backgrounds into the workforce, **credentialing** of GPs is a matter of judgement. This assessment is best conducted by peers, by the kind of GP that has contributed to the excellent record of rural obstetrics. On no account should it be given to specialists with lack of rural knowledge and/or potential personal or craft conflict of interest.
- b. **Advanced training** in obstetrics and anaesthesia is available during rural GP training to Australian graduates and will accelerate from 2002 on. Refresher courses and attachments are available, but the State Government needs to provide a level of support for ongoing continuing medical education and skills maintenance, to often isolated practitioners, that is at a level that will encourage continuation of this vital service.

This level of support is far from adequate in current CME arrangements. The advanced emergency obstetric course ALSO may be available soon.

- c. There is no evidence to support a move away from the **team model of rural obstetrics**. The GP and the midwife share responsibility for the conduct of labour, with the GP taking ultimate responsibility for decisions. To increase flexibility and optimise human resources the midwife could however move to being on call as opposed to being on duty when there are expectant mothers. Importantly, there is potentially an observational and care role for non-midwife nursing staff once mother and child are stable, when the midwife can be on call, as has been recommended for review⁽⁴⁾.
- d. Provision of capability for **Caesarean section** is a location by location matter. Provision implies a functional operating theatre in use for elective surgery and stabilisation of emergency cases prior to transportation. The needs of the community are paramount. This area has been addressed by another RDAV policy statement⁽⁵⁾. Rural GP skills require a critical mass of inter-related ongoing experience for maintenance. No caesarean capability does not necessarily preclude obstetrics, depending on the location, and this requires review and study. The Monash School of Rural Health could be funded to conduct this. There are locations in Victoria such as Mt Beauty providing safe obstetrics that have never pretended to aspire to Caesarean Section. The presence of a network of hospitals can be a factor in organisation and provision of effective obstetrics. Such key services require more scientific and less political input in determining location than at present. The rationalisation that is occurring in rural care must not allow the enhancement of one community at the expense of another.

Recommendation 3. Good equipment.

Up to date anaesthetic and obstetric equipment including tochography, infant resuscitation units and humidicribs are required. Properly negotiated these will usually be funded by the community. Standardisation facilitates the process of on site maintenance.

Recommendation 4. Good support.

The State Government has been hugely and justifiably supportive in meeting the cost of indemnity. The public purse needs further protection by according rural obstetrics the profile and respect it deserves by its achievements. To preserve the confidence of the public the Government needs to have better advice on the conduct of malpractice suits. These should be contested where possible and the evidence and situation thoroughly examined. Rural Obstetrics remains a vital necessity and needs to be fully defended. An affirmative Departmental philosophy could be extended to regional and local management to prevent the placing of constraints upon medical and obstetric practice.

Recommendation 5. Data.

In no state of Australia is it possible to establish patterns of obstetric outcomes based on place of residence. Revision of data collection and computerised databases would make this a relatively easy task. The RDAV is in no doubt as to the validity of previous studies. However there is a need to monitor the effect of widespread closure on mortality patterns at least. For this some retrospective study to about 1985 would be desirable and again School of Rural Health could be funded.

2. SUPPORTING OBSERVATIONS AND DOCUMENTATION

The figures from rural units completely confirm that effective transfer of high risk cases by antenatal screening combined with effective safe obstetric practice has reduced rural perinatal mortality to a minimum. Whereas sophisticated interventions in unexpected and unforeseeable emergencies may save some mortality and morbidity, the overall figure will be offset for rural women in larger units by troubled labour, caused by maternal anxiety, in unknown and distant institutions, with resultant instrumentation and operation, and by mishaps resultant from lengthy transportation during labour. Unassisted and hence much safer labour and childbirth are up to 50% more common in rural units, where the primary attending GP obstetrician is of much greater experience than junior staff in metropolitan and provincial units.

The 1983 Victorian State Inquiry⁽⁶⁾ found a direct ratio of safety to smallness. Units under 50 deliveries a year of any size, even if they deliver less than 25, were found to be extremely safe. **Perinatal mortality was found to double (5.5 to 10.5) in units over 50 and tripled (15.0) in tertiary units.** Bush Nursing Hospital standards were consistently described as “extraordinarily high” in annual reports by Professor Roger Pepperell⁽⁷⁾. Judith Lumley studied small unit safety⁽⁸⁾, and later chaired the **1990 Ministerial Review of Birthing Services in Victoria**⁽⁴⁾. Many rural submissions were received. The report notes (p49): “unlike other places, Victoria has no established policy of closing small units in rural areas” and “the closure of such units is not warranted on safety grounds.” In 1983 Prof. Pepperell (Quoted 6 p6) speculated that it would be difficult to envisage a further reduction (in the perinatal mortality of 5.5 at bush nursing hospitals) “even had the babies been delivered in teaching hospitals”. To gainsay this and emphasise small unit safety the VBNA figure in 1988-9 had fallen to 1.8 while the State rate was still 10.4⁽¹⁰⁾. In 1991 Professor Quinn wrote⁽⁷⁾ that the VBNA figures were “**unparalleled (ie in the world) and should be noted by Government**”. Since then Victorian Health Authorities have allowed most of these units to close. The 1998 State perinatal mortality published 2000 was 7.3, achieved at the cost of assisted labour in nearly 50% of women and a caesarean section rate of 21.0%, still four times that of the VBNA in 1988. The figures for larger GP run units are similarly impressive, and equal to those of the best units^(3 and 9).

The **NSW 1989 Shearman report**⁽¹¹⁾ likewise found safe maternity care and effective transfer of high risk cases in NSW, significantly noting the much higher rate of completely spontaneous deliveries (75% Vs 54%), which we argue substantially reflects decreased maternal anxiety. The 1993 **Tito Review of Professional Indemnity**⁽¹²⁾ likewise found a high standard of care in 5950 NSW rural GP confinements, indicating that the community needs to be more aware that rural GPs are providing the “same quality of care as the specialists”. Young⁽¹³⁾ studied an isolated unit in Penrith, UK and found that “the low mortality, the low level of intervention and the preference of women all support the retention of isolated units”. Even where there were no referrals, and all 730 mothers *without exception* were delivered locally (Cohuna 1970-80), the perinatal mortality rate was significantly lower than State or National figures, *with a caesarean rate of 2.3%*⁽¹⁴⁾. Comparison studies between outcomes for rural women delivering in their home and at distant hospitals are definitely called for.

In 1983 NSW classified units under 80 deliveries per annum as “**unviable**” and closed 35. The seemingly unremitting bureaucratic hostility to small units at local, regional and State level is hard to fathom. The pleas of communities and the wishes of Mums-to-be are ignored and the matter is left to the next State election. No ongoing appraisal which takes into account past findings seems to exist. There is no interstate or national departmental collaboration. **The view that closure will lead to increased maternal and baby mortality rates** has much to support it ⁽¹⁵⁾. A retrospective and continued State database to study this matter should be a priority. *Finance is not an issue.* Shearman ⁽¹¹⁾ and others ^(13,16, 4p22) have noted the low cost of small units.

Ultralow perinatal mortality rates in Victoria were achieved by GPs and midwives making decisions unsupervised, taking advice when they saw fit. Any professional guidelines and recommendations therefore should remain just that, and flexibility of local practice must be respected ⁽¹⁵⁾. Any bureaucratic interference in local practice is likely to worsen outcomes. The actual need for Caesarian section facilities needs further study ⁽¹⁵⁾. To date, reviews e.g. Woollard ⁽¹⁷⁾ have not suggested a change in figures when Caesarians are not performed. Units such as Mt Beauty have practiced safely for years without the availability of onsite caesarian section by judicious application of clinical principles.

Whereas the supply of GP proceduralists appears to be turning round there seem to be currently lower numbers of qualified midwives in rural areas. (Though units are closing even where there are sufficient of both.) There is widespread sentiment that in small units the 24-hour ward presence of a rostered midwife per se, is not necessary after the process of delivery is completed. On call is sufficient. Certainly this is not obligatory in home births. The legislation does not require it. However the Nursing Council of Victoria, and subsequently the Nursing Board, has insisted that no non-midwife attend in any way a mother lying in ⁽¹⁸⁾. *A review of this requirement has been recommended by the Department* ^(4, p4).

Rural Obstetric practice, like all rural medicine needs adequate defence. The wise decision of the State to meet obstetric indemnity costs averted a major crisis in 1996, when rural GPs threatened to withdraw their services. Malpractice suits will however occur from time to time and attract a high profile because of biased perceptions towards rural practice. Such cases need adroit handling to maintain public confidence. This unfortunately did not occur in one case in 2000 when the Victorian State solicitors appear from the information to hand to have failed in their duty to the rural hospital and GP concerned ⁽¹⁸⁾. No evidence was presented to the settlement hearing even though the defendants had denied liability, and there was no request for the usual agreed confidentiality, thereby exposing them to public infamy when the ensuing judgement was based solely on the claimants’ allegations.

SUMMARY

The evidence is unequivocal, there is not, and never has been, any valid argument for closure of small rural obstetric units on grounds of safety or smallness. It is inevitable that such closures will lead to increasing morbidity and mortality for rural women and their babies.

The State Government needs to provide a clear policy direction on this matter to hospital boards and the rural communities they serve, and follow this with funding support to maintain services and facilities. Additionally the State Government needs to ensure appropriate studies are undertaken to investigate these issues, and continue its support of practitioners providing this service with indemnity arrangements and improved assistance for CME.

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