



O&G

MAGAZINE

# INFORMED BIRTH

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RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, present and future. RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

# From the President



**Dr Gillian Gibson**  
President

Informed birthing and shared-decision making are vital components of maternity care, shown to significantly improve outcomes for women. However, a landmark parliamentary inquiry earlier this year in Australia revealed that birth trauma remains widespread and pervasive. Improving birthing experiences will require a sustained, collective effort from medical professionals, health practitioners, policymakers, funders, and administrators. This edition of O&G Magazine, which spotlights Informed Birth, is a testament to RANZCOG's ongoing commitment to this essential aspect of maternity care.

## Response to the NSW Select Committee on Birth Trauma

In response to the report of the New South Wales Select Committee on Birth Trauma, the College issued a comprehensive statement and has sought a meeting with the Hon. Ryan Park, New South Wales Minister for Health, to provide RANZCOG's input to the recommendations. Additionally, the College has also convened a working group actively collaborating with Birth Trauma Association and the Australian College of Midwives to develop trauma-informed education for all multi-disciplinary providers of maternity care.

The College has achieved significant advocacy milestones in recent months as we continue to advance women's health across Australia and Aotearoa New Zealand.

## Addressing persistent pelvic pain

Persistent pelvic pain affects up to 24% of women worldwide, significantly impacting their physical health, emotional wellbeing, and overall quality of life. In Australia, the existing Medicare Benefits Schedule (MBS) doesn't cover longer consultations required to investigate pelvic pain, often leading to challenges with treatment. To address this, RANZCOG worked with the Department of Health and Aged Care, highlighting the inadequacies, and making recommendations to reform the existing structure.

As a result, two new items will be added to the MBS from July 2025 to help patients access improved care, requiring an investment of \$49.1 million. These new items will offer a higher fee for longer initial and subsequent consultations for complex gynaecological conditions, and a new extended 60-minute MBS item is also being introduced for GPs, which will ensure they are fairly compensated for the additional time required to examine patient's histories and symptoms.

In addition, RANZCOG recently made a submission to the Victorian Inquiry into Women's Pain - a critical initiative aimed at amplifying the voices of girls and women

living with pain. The submission addressed the issue of persistent pelvic pain often being misattributed solely to gynaecological causes due to medical gender bias, leading to delayed diagnosis and treatment. RANZCOG called for systemic change and education to eliminate bias, while also promoting multidisciplinary approaches to pain management, and ensuring timely, compassionate, and comprehensive care for women.

## Pelvic floor health campaign

In Aotearoa New Zealand, RANZCOG undertook public awareness activities that coincided with World Continence Week. Media and social media activities supported the work of Continence New Zealand and a RANZCOG webpage was launched with resources including media materials, case studies and the content developed for our advocacy work for clinicians and the public. Public promotion of pelvic health messages will continue on social media through the remainder of the year and RANZCOG is working closely with Te Whatu Ora Health New Zealand, the New Zealand College of Midwives and Physiotherapy New Zealand on education, assessment and treatment of the pelvic floor during pregnancy.

## Enhancing the rural workforce

RANZCOG's Rural, Regional, and Remote Women's Health Strategy, introduced at the 2024 Regional Symposium, is focused on addressing the unique challenges faced by both rural practitioners, and women accessing services in underserved communities. The strategy seeks to enhance services in rural, regional and remote areas by tackling workforce shortages, expanding training opportunities and improving service delivery.

With the strategy still in the early phases of implementation, RANZCOG has already been advocating for workforce reform, providing key evidence to the NSW Legislative Assembly's Select Committee on Rural, Regional, and Remote Care, and by participating in the Department of Health and Aged Care's Medical Workforce Advisory Collaboration (MWAC). These efforts are expected to make a difference by improving access to comprehensive care in rural areas, fostering a more sustainable workforce, and enhancing health outcomes across these communities.

## Maintaining a role in Specialist International Medical Graduates (SIMG) assessment

RANZCOG is focusing on expediting pathways for Specialist International Medical Graduates (SIMG) and has highlighted the essential role of specialist colleges in assessing

international registrants and supporting their integration into the Australian healthcare system.

In a submission to the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA), RANZCOG emphasised that the continued involvement of specialist medical colleges is crucial for maintaining clinical excellence. This involvement also ensures that SIMGs are well prepared to meet Australia's diverse medical and cultural needs, supporting the development of skilled professionals ready to contribute effectively.

In Aotearoa New Zealand, RANZCOG also responded to a proposal from the Medical Council of New Zealand to introduce an expedited pathway, along with several other proposed changes. The College's role in SIMG assessment is more limited in New Zealand than in Australia, in that RANZCOG acts as an advisor to the Medical Council who makes decisions about registration, and it prescribes and manages supervision of SIMGs. As in Australia, RANZCOG's focus in responding to consultation was on maintaining clinical standards while also supporting more efficient assessment and registration of SIMGs, who are a vital part of Aotearoa New Zealand's O&G workforce.

#### **RANZCOG Roundtable on Improving Access to Medications & Devices in Pregnancy and Women's Health**

In May, RANZCOG held a roundtable in response to medicines and devices commonly used in pregnancy and women's health being unavailable in the Australian market or in critical short supply with potentially serious implications for the day-to-day care of patients. The RANZCOG Roundtable on Improving Access to Medications & Devices in Pregnancy and Women's Health, convened

key stakeholders to workshop solutions for improving medication and device supply and use, with the objective of bettering health outcomes for women and supporting College members and trainees' ability to deliver safe care.

#### **Private Practice Roundtable**

In November, RANZCOG's Private Practice Committee will convene a Roundtable, which will bring together stakeholders including College members, the Australian Department of Health and Aged Care MBS Members Services, and private health insurers to consider current challenges, and ensure a sustainable future for private O&G practice in Australia.

#### **A personal thank you to our members**

Volunteer members play a crucial role in the College's advocacy efforts by dedicating their time and expertise to submissions, meetings, workshops, consultations, and developing practical solutions. Their invaluable contributions help address challenges and disparities in our healthcare system, driving forwards excellence and equity in women's health. Looking ahead, RANZCOG remains dedicated to advocating on issues affecting members, trainees, and the broader women's health community. I hope you enjoy this edition of O&G Magazine and thank you for your continued interest in the College.

#### **References**

1. Report of the New South Wales Select Committee on Birth Trauma [internet]: Report (nsw.gov.au)
2. Victorian Department of Health [internet]: Inquiry into Women's Pain (health.vic.gov.au)

# LEADERS **F** IN **FOCUS**



**Dr Paddy Moore**  
FRANZCOG MBCHB, BA, MSTR Bioethics

This feature sees Paddy Moore in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter  
#CelebratingLeadership @RANZCOG



**Professor Susan Walker**  
A.O

Professor Susan Walker A.O. is the Head of the Department of Obstetrics and Gynaecology. She is Co-Director of Mercy Perinatal, a three-pillar centre of excellence in clinical care, education and research in high-risk pregnancy, based at Mercy Hospital for Women in Melbourne.

Sue founded the Perinatal Medicine Department at Mercy Hospital for Women, which has flourished into a tertiary referral site for some of the highest risk pregnancies in Victoria. Sue obtained her FRANZCOG and MD in 2000 before completing MFM sub-specialty training in 2004 and undertaking a Maternal Fetal Medicine fellowship at the world leading Mt Sinai Hospital, Toronto in 2007.

In 2011, she was appointed to the Sheila Handbury Chair of Maternal Fetal Medicine, University of Melbourne. In 2018, Prof Walker was awarded Officer, Order of Australia for distinguished service to the field of obstetrics and gynaecology as an academic and clinician, and for her enormous contribution to professional organisations. Sue has developed the Fetal Medicine at Twilight educational

series, which attracts a large local audience and is streamed live to sites across Australia and overseas. She instigated the bi-annual Medical Disorders in Pregnancy Symposium. She has been on the organising committees for several national and international conferences and co-directs the annual Global Obstetric Update conferences.

**Sue, tell us what attracted you to your field/s of interest?**

I came to O&G via a circuitous course, having wandered through my post grad years doing some physician training, then wanted to try General Practice. It was during my Family Medicine Program training that I did a Dip Obs and became hooked. Probably the same way everyone gets hooked, you see someone fantastic, and you want to be like them. For me, that was my first registrar, Tom Manolitsas and the then Head of the General Gynae clinic at Austin hospital, Peter Grant.

After my basic training, I decided to do a Doctor of Medicine. That was the time when I had my first two babies. On finishing my research, I had become invested in high-risk pregnancy and decided to train in maternal fetal medicine – and have my third baby while in training. What was optimistically referred to as the 'MFM unit' was actually one outpatient room in the University Unit Antenatal clinic back then. But now it's the thriving clinical hub of Mercy Perinatal, a terrifically fabulous place to work in the areas of complex maternal medicine, fetal medicine, fetal diagnosis and therapy, prenatal genetics and fetal surveillance.

**From very early on in your career you were involved with leadership positions. Was this by design or default?**

I honestly don't know! A bit of both, I think. I do like thinking about people, places, partnerships and problems- how can we make them better? But I was also enormously fortunate to have had people look out for me. There were people who believed in me and who would help identify or create opportunities, encourage me to apply for positions and support me in the 'what have I done?' moments. It's my job now to pay that forward. To look out for others, to teach and mentor them, to ignite a belief in themselves, to create opportunities.

I often think about the see-saw we are perched on in our professional careers, the yin and yang of ambition at one end, and altruism at the other. We need both. We want clinicians and researchers who are hungry for success; we want innovators, designers, dreamers. We want people who have novel thought, big ideas and communicate them well. But we also need clinicians and researchers who are altruistic; who look out for juniors, who are generous, who mentor and sponsor others, who go second last on the paper, who contribute to hospitals and professional societies and communities.

With increasing seniority, these two ends of the see saw come closer together. My ambition, and what success looks like to me now is more tied up in the successes of others. This means looking out for students, junior doctors, midwives, those coming up behind us, providing education

and mentorship and support. Creating environments where people feel respected, valued and that they belong. 'Society grows where old men plant trees knowing they will never sit in their shade.'...and all that.

**What are the leadership achievements you're most proud of and why?**

Well, I'm proud of my trainees who pass their exams and go on to become my colleagues. My PhD students who have become independent researchers and remain trusted collaborators. Also, my consultant colleagues who have gone on to become amazing leaders themselves, but still stop by to say hi. I'm proud of the collaborative partnerships we've created. I'm proud of the difference we can make in the life of a medical student: when they remember something you said, and it's been an 'Aha' moment for them. I'm proud of the impact we make in the lives of families we care for. I'm proud of Mercy Perinatal and how it's become a trusted source of engaging and accessible education for maternity care providers everywhere.

**You yourself have established a highly successful leadership forum, now in its third year. Can you tell us about this, its origins, what you hoped to achieve from it and insights gained.**

Yes, this has been a yearning for me and I'm not quite sure where it came from. But I've wanted to create an event that feeds people and fills their cup. Get them out of the weeds and the bone-aching fatigue and bureaucracy, which we all struggle with. Give some practical advice for everyday leaders and create and cultivate a community of practice with some inspiring leaders across all disciplines and career stages.

My daughter is living in London at the moment. Earlier this year, I asked her: 'Honey, how are you surviving the winter?' And she said: "Mum, the hardest thing about London in winter is you never see a horizon. The clouds are low, the buildings are high. At home, there are horizons everywhere. I miss them." And it struck me as such an astute observation. We are all physical and metaphorical horizon seekers. So, this year's symposium is 'Horizon Chasing: rediscovering your best life in healthcare'. Come along. Whether your horizon is in your current role, or making change or making a move, let us help!

**Do we adequately address leadership skills in our training? Do you have any suggestions for RANZCOG on this?**

I think we are moving toward this but could probably do more. Capable clinicians often find themselves in leadership positions, and it's assumed that 'you'll be great at it because you're a great person and clinician'. And they probably will be. But we could supercharge their performance by upskilling them in leadership specific skills and knowledge. Areas such as finance and how the business of health is done, how to write a business case, change management, leading people, creating and maintaining great workplace culture. There is also the 'knowing yourself' piece – dealing with failure, imposter syndrome, bringing your EQ to work.

**How would you describe your leadership style?**

Well, it's hard to say. It's definitely not 'Leadership of outstanding time management' or 'leadership of not

taking on too much'. I think my style is more, 'Come on! Join the circus! It will be fun!' But perhaps the description of transformational leadership sort of resonates with me, that is gaining the trust and respect of the team, and empowering others, but also being able to inspire and get people on board with a vision.

**How do you balance your roles?**

I'm writing this at 1.30am. How do you think I'm balancing my roles?!

**What forms will your leadership take going forward?**

That's a great question. I'm keen for the 'what's next'. Although I don't know exactly 'what shape' that looks like yet. But I hope I get the chance to grow as a leader. Have an impact. Be both kind and wise. Lead with integrity and humour and equanimity. With the right balance of grit and grace and help others to grow.

# Updates from our Research and Policy Team



## Prof Cindy Farquhar

MB ChB, MD, FRCOG, FRANZCOG, CREI, MPH, MNZM, PMMRC

Acknowledging the theme of informed birth, RANZCOG clinical guidance statements and guidelines that help inform this topic include:

- C-Obs 2 Home Birth (updated July 2023)
- C-obs 31 Care in Labour (updated March 2024)
- C-Obs 39 Caesarean Birth on Maternal Request (updated July 2023)
- C-Obs 38 Birth After Previous Caesarean Section (update currently underway)

This quarter the team have received approval to rename all College clinical statements developed using an evidence-based process to Clinical Guidelines. By using a singular term, RANZCOG is brought into alignment with other medical colleges. We also hope it is now clearer to members which of RANZCOG's clinical guidance documents are new or updated.

All evidence-based College statements published since 2022 (new process) will be known as clinical guidelines and the working parties convened to support this work known as Guideline Development Groups (GDGs). Please note this name change does not apply to all other RANZCOG guidance, including endorsed content, position statements, general statements (C-Gen), training, workforce, and practice issues statements (C-Trg, WPI) and clinical guidance statements that receive an interim update only (title change to clinical guideline to be applied at next opportunity for full update).

### New and updated RANZCOG guidelines

The Research and Policy Team and Women's Health Committee have published two new guidelines this quarter:

- C-Obs 53 Substance use in pregnancy – this new guideline combines two previous statements: Smoking in pregnancy and Substance use in pregnancy. There are nine recommendations and 10 Good Practice Points providing advice to clinicians about the use of alcohol, nicotine (smoking and vaping) and other drugs (including opioids, cannabis, amphetamines, cocaine, benzodiazepines and volatile substances (inhalants) during pregnancy.

- C-Gyn 3 Contraception Guideline – these new "signposting" guidelines have been adapted by the RANZCOG guideline development group from 14 guidelines of the Faculty of Sexual and Reproductive Health of the Royal College of Obstetricians (RCOG), including:
  - Combined hormonal contraception
  - Intrauterine contraception
  - Progestogen-only pills
  - Progestogen-only implants
  - Progestogen-only injectables
  - Barrier methods
  - Fertility awareness methods
  - Quick starting contraception
  - Emergency contraception
  - Male and female tubal ligation
  - Contraception after pregnancy
  - Contraception and young people
  - Contraception for women aged over 40
  - Overweight and obesity
- C-Obs 63 Reproductive Carrier Screening – interim update to provide information about changes to MBS in Australia following addition of new item numbers for three genetic conditions- cystic fibrosis, spinal muscular atrophy and Fragile X.

Thank you to all fellows, trainees, midwives, community representatives involved in developing and updating this work. We would also like to thank RANZCOG members who provided consultation feedback, the Women's Health Committee (particularly Dr Scott White, WHC Chair) who oversee guideline development and the work of our team and College Council for review and approval of the final documents.

These new guidelines are now available on RANZCOG's website: [ranzcog.edu.au/resources/statements-and-guidelines-directory](https://www.ranzcog.edu.au/resources/statements-and-guidelines-directory)



## RANZCOG Signposting Guidelines

### Why and when does RANZCOG signpost to other organisation's guidelines?

We can 'signpost' where we identify high quality evidence-based guidelines developed by other external organisations, such as the Faculty of Sexual and Reproductive Health (UK). Signposting is a pragmatic approach to evidence work and avoids duplication of effort. Signposting guidelines are assessed for methodological quality. The members of the guideline development group each assessed these guidelines for local context and made recommendations for adapting. The FSRH has approved our changes.

We hope these guidelines will be helpful to RANZCOG members and we would love to have your feedback about the value of these guidelines.

### Attention all RANZCOG Trainees

From February 2025, there will be an advanced training module on Evidence Based Medicine. This is an opportunity to work with the Research and Policy Team on RANZCOG Guidelines. Please contact Professor Farquhar (using the email address below) if you are interested in this provisional module.

### Updating patient information pamphlets at RANZCOG

We are also responsible for updating the very useful patient information pamphlets (known as PIPs). If you come across anything you think needs updating, please get in touch with us. We plan to update them after each guideline is completed, but in the interim, we will update any areas that are highlighted to us as out of date.



Research and Policy Team. (L-R) Angela Hunter, Kate Smith, Professor Cindy Farquhar, Katie Coulthard, Michelle D'Almeida

The Research and Policy Team can be contacted at:  
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A pregnant woman in labour during a home birth. Photo: Adobe Stock

# Informed consent: A vital conversation



**Kate Hicks**  
BRM, MTM, Birth Trauma Aotearoa



**Associate Professor Angela Ballantyne**  
PhD Bioethics

If we are to look at informed birth, we need to also look at informed consent.

According to research,<sup>1</sup> in Aotearoa, 50 women/birthing parents per day will report their birth as psychologically traumatic. Many more women will sustain some level of physical birth injury. Psychological trauma is characterised by intense anxiety, helplessness and loss of control.<sup>2</sup>

For some, their birth trauma – whether psychological or physical – will be unavoidable, but for many others their trauma is entirely avoidable and results from a lack of informed consent and a lack of agency during their birth.

Both the RANZCOG ‘Statement on Patient Consent and Duty to Inform’ and The Medical Council of New Zealand’s ‘Statement on Informed Consent’ note that informed consent is an interactive process between the doctor and patient, which gives those caring for the patient permission to proceed with treatment. It is the doctor’s responsibility to ensure informed consent is obtained and the patient has a right to refuse treatment.

Consent practices are inherently valuable because they promote autonomy; but they are also instrumentally valuable because they foster trust and can facilitate a safe and open therapeutic relationship.

## The experience of informed consent during labour and birth

Those of us working in the maternity sector have a robust understanding of the definition of informed consent, but what about the experience of it? Aotearoa’s birth trauma community, sadly, holds many experiences where informed consent in the birth space was not obtained, the relevant information was not conveyed and where the birthing parent did not feel able to decline consent for treatment.

We often hear from the birth trauma community comments such as “I didn’t know this could happen” or “they never told me...” Information is a key component of informed consent. Whether in the birth space or within everyday life, we use information to make decisions that are best for us and our whānau. Information is power and we cannot make appropriate decisions, and we certainly aren’t empowered, if we don’t have all the information. Information needs to be shared at all stages of pregnancy, labour, birth and postpartum. Improved access to safe childbirth education is one piece of the information pie, but it is not a silver bullet.

Effective communication is a vital part of informed consent being an interactive process. This includes the language used and the ways in which situations, risks and treatments are explained to pregnant and birthing parents.

Georgia’s\* experience of discussing a VBAC at an obstetrician appointment included the doctor saying, in front of Georgia’s husband and toddler: “Without constant monitoring, your baby will die” and: “You or your baby will die, you could leave your son without a mother.” The words spoken to Georgia and her family are coercive; coercion is not communication. Coercive remarks also often leave mothers feeling like they have no option but to accept the suggested treatment.

Grace speaks of how “they wanted me on the bed instead of the floor. That’s when the hands on started. Just because the mother changes position doesn’t grant you access to their body without asking”. Outside of the birth space, the need for consent before one person touches another is being quickly absorbed into our societal understanding. This needs to also happen inside the birth space.

Another part of effective communication is listening. Anna shares her story of not being believed almost leading to fatal consequences. “I was fobbed off by multiple nurses and midwives that my symptoms were all in my head and was about to be sent home when I spoke up one last time. I was later told by the obstetrician that if we had gone home my baby and I would have both died. That comment still haunts me.”

## The ethics of consent

Informed consent is important because it is morally transformative. Consent transforms an act that would be both illegal and unethical into an act that is socially condoned, ethically legitimate, and morally praiseworthy. To cut someone open without their consent is assault. But to, for example, surgically remove a tumour on a consenting patient is morally commendable. For consent to be valid and to have this transformative power it requires that the patient is competent to make medical decisions, is free from coercion and is fully informed about the procedure, risks, potential benefits and other options.

In the story above, the birthing woman is told that her baby “will” die. What makes this statement coercive? Coercion requires the use of physical force, or explicit or implicit threats of harm, to make someone do something against



their will. Essentially it leaves the patient with no reasonable choice but to comply and, in this way, coercion undermines autonomy and informed consent.

Health providers assisting with birth may well be genuinely concerned about potential risks to either the mother or foetus and have an ethical duty to inform women. The statement that the baby “will die” is potentially coercive because it would be rare for the health provider to know this with certainty. It is reasonable for the birthing person to interpret this statement as a threat, rather than an effort to communicate. The key thing about coercion is that it wrests decision-making power away from the patient.

It is important to think about coercion within the social power dynamics at play in birth. Health providers have power over patients because patients are often sick, and this makes them vulnerable. Health providers are the gate keepers of a resource that patients need, and health providers have social and epistemic authority. Epistemic authority means we recognise health providers as having authority and power based on their professional knowledge and training. In this context, a coercive threat doesn't need to be explicit. It can also include an implicit threat to withhold medical care or attention to which the patient is entitled.

Power differentials often seem much more obvious to the disempowered person and much smaller to the person in a position of power. Many women will say birth is one of the most difficult things they have experienced and is a time at which they were at their most vulnerable. Birth trauma is associated with being dismissed, ignored, belittled and bullied. This is a form of epistemic injustice<sup>5</sup> which is an

injustice related to knowledge, such as unfair distinctions in authority, unwarranted distrust, and in this case, the unfair downgrading of women as sources of relevant knowledge about their bodies and births.

Health providers may underestimate the power they have in relation to patients and be unaware of the extent to which patients try to perform as a “good patient, good woman, good mother” to please their midwives, doctors and nurses. This can hamper a health provider's ability to identify birth trauma either during or after birth. If a patient has lost trust that you are on her side and listening to her, she may go into survival mode, minimise interactions with you, communicate less honestly to avoid making herself more vulnerable, and may be aggressive or obstinate as a form of self-protection. All of this can pose challenges for health providers trying to navigate women towards a positive birth outcome.

Understating this behaviour in the context of social and epistemic power can help providers see that patients are sometimes using the only resources available to them to try to regain a sense of control in a situation that feels threatening, overwhelming and scary. Demonstrating patience, listening and humility can help diffuse tensions and nurture trust. Assertiveness, pressure or implicit threats may seem appealing to providers if they lead to a prompt and safe delivery, but they can cause long-term trauma and harm to the mother and, consequently, their baby. Delivery of a healthy baby is no indication that the birthing person is OK. And we know from public inquiries, empirical research and lived experience that providers are often unaware that their patients have experienced trauma.

### Where to from here?

When genuine informed consent occurs in the pregnancy/ birthing context, its positive impacts can ripple out into the entire whānau. Maia's experience of informed consent involved having information shared regarding "all my questions, about possible outcomes and options, including if I chose to do nothing." This experience left Maia feeling confident and supported.

If we are to see any change in birth trauma prevalence, we need more conversations about informed consent and women's agency during birth. Consumers need to have these conversations with practitioners; but they are also needed among the professions and stakeholder groups within the maternity sector.

These conversations should be open, honest, upfront and solutions focused. They need to include all stakeholders, particularly the birth trauma community and the many insights that can be gleaned from this community's combined experiences.

These stakeholder conversations can result in agreement on the changes needed to improve informed consent practices; for example, improved training opportunities and increased resourcing across the maternity sector.

Interactions between birthing parents and those caring for them directly impacts the birth experience. Birth experience, in turn, directly impacts the birthing parent and their whānau into the future. We have an opportunity to greatly improve whānau experiences of birth, and therefore whānau life after birth, if we kōrero about, and then improve, informed consent practice.

*\* Names have been changed to protect privacy.*

### About the authors:

**Kate Hicks, BRM, MTM** is Founder and Chief Executive of Birth Trauma Aotearoa – a registered charitable trust undertaking education, advocacy, research and support services regarding both physical and psychological birth trauma. Kate is also creator of the Aotearoa-focused My Birth Story birth trauma support website. Kate lives in rural Manawatū.

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# A breech delivery in 1962

**Dr Russell MacDougall**  
MBBS, FRACGP

Here, Dr Russell MacDougall shares a memorable experience of a breech delivery that took place in 1962 in the early days of his medical career.

I graduated in December 1960 and was registered in the same month. By that time, I'd already developed a strong belief in the importance of communication in medicine. I was especially inspired by a brilliant lecture given by the late Bill Rawlings on breech delivery in his role as Obstetrician/Gynaecologist at the Royal Women's Hospital in Melbourne.

As the salary for RMOs was very low it was common for RMOs to do locum work for GPs, and, at the time, obstetrics was a part of general practice. I was working for my father (a GP) as a locum in a small country town, when I had to take over the care of a multigravid who was close to term with a twin pregnancy. One vertex, the other in breech position.

When I arrived at my father's practice, he was ready to leave. Before he left, he said: "There's a lady in labour at the local hospital and she's having twins who are breech and in vertex presentation." He added: "This is her 4th pregnancy, she has a big pelvis, and a few hours to go. If you need help, 1B (in Warrnambool, 20km away), will give you a hand if you call him." And with that he drives out the front gate.

I did call 1B and he said: "You will be fine Russell, any problems call, and I will come out". This didn't feel very reassuring given his response time was likely more than the time in which an emergency could develop.

As I turned to go upstairs, the phone rang: "Your lady is on view, come now". When I walked into the labour ward, there were a few long faces on the nurses. I felt sure they'd have preferred the older Dr MacDougall.

Nonetheless, the vertex delivery went very smoothly and soon the legs appeared of the second baby. All this time I was straining my mind to recall breech deliveries and the details of the lecture on this topic by Dr Bill Rawlings. He had an excellent lecture style, and the details came

back readily, albeit disjointedly. Some key helpful phrases that came to mind were: "Never rush the after coming head; "Once baby is breathing through their mouth, cord pulsation does not matter". More similarly fragmented directions from Bill's lecture popped into my head, when suddenly my mind arranged itself, a sequence developed, and things went like this Bill: "Cut a deep episiotomy."

So, I said to the Sister on duty that I needed local anaesthetic, and she brought a glass syringe as instructed but just before she gave it to me, it fell on the floor and smashed to smithereens. "Another syringe please Sister", I said. I then injected the local anaesthetic and cut the episiotomy: by this stage one of the babies' body was part way out.

Bill: "As the trunk comes out grasp the feet and lift, don't pull, just lift and as the trunk advances you will be able to see the baby's mouth. Suck out whatever is in the mouth of the baby and then the baby will be breathing air. Once this occurs, the cord is of no use, do not even touch it, it may stop pulsating, ignore it. Doctor, the cord has stopped pulsating, what will you do?" "Nothing at all," I said.

Bill: "Now you have the baby breathing air, time is in your side, in your mind take the time it would take to drink a cup of tea. And in that time, without hurrying the head, it should come through."

I duly tried to estimate the time it takes to have a cigarette and, sure enough, the head came through the vulva and the baby was delivered. Once I had repaired the episiotomy and with two healthy babies in their cribs, I took my leave.

I walked outside on that warm January day, and the sky seemed the most intense blue I had ever seen, and my thoughts returned to Dr Bill Rawlings lecture. The fact that vaginal breech delivery is now virtually obsolete does not diminish the fact that when confronted with a very difficult clinical problem his teachings were enormously helpful to me. Indeed, this letter (turned article) is to put on record my sincere gratitude – thank you Dr Bill Rawlings.

# RANZCOG's Historical Collection: Dr Felix Meyer

## Greg Hunter

Archivist, Historical Collections Administrator

This issue we look at a prominent early figure in the history of obstetrics and gynaecology in Australia – Dr Felix Meyer.

Born in Melbourne in 1858, Meyer was a gifted school student in his early years. In 1873, he commenced studies at Wesley College and was named dux of the College in 1875, winning the matriculation examination exhibitions in classics, English, French, history, and geography in that year.<sup>1</sup> Meyer's true passion, however, was medicine.

Meyer was a graduate of the University of Melbourne's medical school, attaining his MBBS in 1880-81 and his MD in 1902.<sup>2</sup> Along with T.R.H. Willis, he was responsible for the foundation of the Medical Students' Society at the University. Following his graduation, Meyer became the sole resident medical officer at the Lying-In Hospital (which would later become the Royal Women's Hospital) from 1881 to 1885. During this period Meyer was very active in establishing a raft of initiatives at the hospital, initiating "both systematic clinical teaching of students and formal training of midwives" and founding "the Victorian Nurses' Association and the nursing journal *Una*, which he edited for five years."<sup>2</sup> Prior to Meyer's tenure, "trained nurses, as we understand the term, did not exist."<sup>3</sup> According to one account, Meyer "was not only an able teacher, but a valued friend of students and nurses."<sup>1</sup>

Meyer subsequently moved into private practice as a specialist in obstetrics and gynaecology, working in that capacity until his retirement in 1935. During his career, he held a number of other positions which exemplified his dedication to his chosen field. He was the President of the Victorian Branch of the British Medical Association in 1894, held the position of Lecturer in Obstetrics and Gynaecology at the University of Melbourne between 1914 and 1918, and in 1927 was a foundation Fellow of the College of Surgeons of Australasia (Royal Australian College of Surgeons).<sup>2</sup> Meyer was also the "creator of the board of examiners for the Victorian state committee of midwifery and its first chairman, 1916; and member of the obstetrical research committee set up by the faculty of medicine in 1925, which led to the establishment in 1929 of the chair of obstetrics in the University of Melbourne."<sup>2</sup>

The College is fortunate to hold a number of items relating to Dr Felix Meyer in its historical collections. This includes a collection of 18 surgical instruments used by Dr Meyer, donated to the College by Dr John Downes in 2000. Instruments include curettes, forceps, a rectal speculum, and a pocket kit for Michel clip application.



Examples of surgical instruments used by Dr Felix Meyer. Left to right: Pocket clip for Michel clip application and removal; Tissue forceps; Rectal speculum. Photo: Jess Bacon



Paper ephemera relating to Dr Felix Meyer. Photo: Jess Bacon

Also included in this donation was some paper-based ephemera relating to Felix Meyer. This interesting collection includes a small Christmas card, some photographs of Dr Meyer, an invitation to the opening of Prince Henry's Hospital Post Graduate School of Surgery in 1937, and two papers written by Dr Meyer. One is on a case of a cyst of the pancreas, written for the Medical Journal of Australia in 1916, and the other is a copy of Meyer's Jackson Lecture paper delivered in Brisbane in 1932 on the topic of 'The Makings of Obstetrics.'

Perhaps most notably, this collection also includes a draft of a letter made out to Professor William Blair-Bell, founder and then-President of the Royal College of Obstetricians and Gynaecologists (RCOG) in March 1930. The letter is written in response to an apparent invitation from Professor Blair-Bell to become a Foundation Fellow of RCOG. In the letter, Dr Meyer writes to "regretfully decline the honour" as he is "within measurable distance of giving up active practice."

In a demonstration of the esteem in which Meyer holds the profession, and his colleagues who practice it, he follows up his decision to decline the offer by suggesting that "the honour of invitation to become Fellows and Members of the College appears to have passed by several names of men of excellent standing." This suggestion is given in his opinion as "one of the oldest gynaecologists here" and from his "experience of more than 30 years' association with the Melbourne Women's Hospital, as well as Lectures at the University." Interestingly, this section of the letter has a line drawn through it, suggesting that Meyer had second thoughts about including it in his response. Still, as the saying goes, it's the thought that counts, right?

*The College's collection of items relating to Dr Felix Meyer were kindly donated by Dr John Downes in 2000. A selection of these items is currently on display at Djeembana College Place in Naarm Melbourne. Members and Trainees are invited to visit the College to view these fascinating insights into obstetrics history.*

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# A YGA adventure in Korea



**Dr Jasveen Kaur**  
BSci, MBChB, PGDip, OMG, FRANZCOG



**Dr Inge Putri**  
MBBS, BMedSci, MRepMed, FRANZCOG

The Asia-Oceania Federation of Obstetrics and Gynaecology (AFOG) Congress drew over 1,400 participants this year. A big focus of the AFOG Congress in Busan in 2024 included tackling the issue of violence against women. In line with the 1 billion dollars pledged by the Australian Government, it has never been a timelier effort. It saw Prof Pisake Lumbiganon, immediate past President, delivering a critical plenary lecture on tackling the toughest challenges in women's health, a call to action in Asia and Oceania, as well as the AFOG declaration on violence against women. The Congress also saw the inauguration of the new AFOG President, Dr John Tait, who became the first President of AFOG from New Zealand. Representing Australia and New Zealand, it was a privilege to witness these highlights at the Congress.

At a conference of this scale, it can sometimes be daunting and challenging to initiate conversations with professionals from different countries. Being recipients of the Mizuno-Ratnam Young Gynaecologist Award (YGA) for Australia and New Zealand, we had the unique opportunity to attend the Community Fellowship Program prior to the Congress and make meaningful connections with colleagues around the world. We were very privileged to be two of 16 YGAs from Asia and Oceania participating in this program. Our program started on the 13th of May 2024. Our days were filled with a mixture of healthcare facility tours, lectures on innovation in healthcare delivery and Korean cultural experiences. Our leader, Professor June Park from Seoul National University Bundang Hospital, graciously took time from her clinical responsibilities to guide us, despite the staffing challenges caused by the junior doctors' strike in Seoul at that time. We are deeply grateful for her dedication and leadership throughout the program.

## A cultural shift

Our first two days focused on maternity care. We started at the Seoul National University hospital, one of the leading medical schools in the country. We heard about the change to a new competency based medical teaching model and curriculum. We were introduced to their fantastic simulation centre, which took up an entire floor. Noelle, an advanced birthing simulator was available to be used, which was something we were familiar with in Australia and New Zealand. The facility also included a medical museum displaying various fascinating artifacts. As professionals in our field, we were particularly excited to see an ancient pair of forceps on display!

After an amazing Korean spread for lunch, we then moved on to a public health centre in the Eunpyeong district. Here they talked to us about various public health initiatives with a focus on making parenthood more appealing to families.

We learnt that South Korea has the lowest fertility rate in the world. The reasons are multifactorial but include a cultural shift of choosing not to have children. Initiatives to support parenthood in South Korea's challenging demographic context include providing tax vouchers to make transport easier for parents to commute between clinic appointments and meet up with other parents for playdates were presented to us. It was so interesting seeing the needs of a different country and how their public health team combatted their unique challenges.

Our second maternity focused day started at the Asan Medical Centre where we were shown maternal fetal medicine facilities and received a talk on fetoscopic procedures carried out in the centre. We then moved onto the Samsung Medical Centre, a private hospital. Most of us were familiar with the electronics brand but we learnt that this expansive medical complex, that looked more like a small town than a hospital, was funded by donations from the tech giant. Here, we saw a dedicated maternity centre for international consumers. People would travel from other countries to give birth in this medical centre, and the outpatient and inpatient facilities are state of the art.



Dr Jasveen Kaur (left) and Dr Inge Putri (right) with President Dr Gillian Gibson



### A deeply enriching experience

On the third day of the Community Fellowship Program, we visited another privately owned hospital, Severance Hospital. We listened to a lecture on the development of the gynae-oncology service, including the concept of a hospitalist. This is a specialist ward gynaecologist whose job is solely to manage ward and post-surgical patients to improve efficiency of the service. Severance Hospital is one of the oldest and biggest university hospitals in Korea, which has more than 2,400 inpatient beds across five hospitals: the Yonsei Cancer Hospital, Rehabilitation Hospital, Cardiovascular Hospital, Eye and ENT hospital, as well as Children's Hospital. We were pleased to know that since the Da Vinci installation in 2005-2022, 64,200 cases have been performed in total, including the use of single port Da Vinci system in the treatment of endometrial cancer, including lymph node dissection.

We also visited the Maria Clinic, a centre providing assisted reproductive technology treatment. In the clinic, the consult room was set up in such a way where patients are able to have their first consult as well as a hycosy ultrasound done in the same visit (if appropriate). In Korea, in an attempt to support reproduction due to the country's low fertility rate, we were intrigued to learn that the South Korean government funds up to 25 IVF cycles for couples that are seeking assisted reproductive techniques. An enlightening question and answer session with the director of the clinic showed us just how varied access to assisted reproduction is in the different AOFOG countries.

On the final day, we visited Seoul National University Bundang Hospital, where there is a dedicated building for simulation. We were able to have first-hand experience in the simulation centre and were able to get our hands on the laparoscopic simulators and laparoscopic box trainers, using the articulating laparoscopic instruments. Medical students and residents were taught caesarean sections using a virtual reality experience. Our Community Fellowship Program was concluded by a cultural visit to the Korean Folk Village where we enjoyed watching a traditional Korean Folk Dance.

We then travelled to Busan for the AOFOG Congress academic program. Before the conference started, we were invited to the President's Night along with all the other YGA recipients. Here, we met the AOFOG executive team and leaders of other national O&G societies across the Asia-Oceania Federation countries. We were presented our Young Gynaecologist Awards and were treated to a dance and song performance by two of our talented YGA colleagues from Nepal and the UK.

We both left South Korea feeling very grateful and privileged to have this opportunity to attend the Community Fellowship Program and the AOFOG Congress. We were able to exchange ideas and share our experience of an Australian and New Zealand perspective to group-based discussions. Other than learning and sharing our experience, this also gave us an opportunity to network with other YGAs from other countries. We are thrilled that we could represent RANZCOG and enjoy this enriching experience. We eagerly anticipate more opportunities like these in the future and are excited to see what Australia can offer for the next Community Fellowship Program before the Sydney AOFOG Congress in 2026.

*Dr Jasveen Kaur and Dr Inge Putri participated in the 2024 AOFOG Congress and Community Fellowship Program courtesy of the RANZCOG Mizuno-Ratnam Young Gynaecologist Award, as supported by the RANZCOG Women's Health Foundation.*



Young Gynaecologist Award recipients from across the Asia-Pacific at the AOFOG President's Night

# RANZCOG scholarships & grants



**Dr Cansu Uzner**  
FRANZCOG, MBBS

Each year the RANZCOG Women's Health Foundation offers a range of grants and scholarships supporting research into women's health.

This year, the Foundation is offering over \$360,000 worth of grants and scholarships. Here, meet one of our previous successful recipients of the RANZCOG NSW Trainee Research grant, Dr Cansu Uzner.

The RANZCOG NSW State Committee Research Grants and Travel Scholarships support research in obstetrics, gynaecology and related disciplines. Aimed at promoting academia as a career these grants provide funding for accredited FRANZCOG Trainees and early career RANZCOG Fellows who reside in NSW.

Dr Cansu Uzner was awarded a \$10,000 Trainee Research grant for her project 'Contrast Enhanced Ultrasound with Pulse Inversion Technology in Gynaecology'. This project utilised a novel testing technique to assess gynaecological organs and pathologies through the use of intravenous ultrasound contrast and pulse inversion technology, currently used in cardiac ultrasound. The project aimed to improve the ability of ultrasound to diagnose difficult to visualise gynaecological pathological conditions and test its potential to be a good adjunct to investigation of gynaecological pathologies for patients who cannot have

MRI scans or high surgical risk patients. Despite the limited findings, this was a novel approach to assess whether contrast-enhanced imaging can aid in diagnosis in ultrasound imaging of pelvic organs. The field of sonology and diagnostic ultrasound in gynaecology has had incredible advances in the last ten years. This has resulted in improvement in non-invasive diagnostic techniques and has opened up possibilities of novel techniques to assess gynaecological pathologies.

Dr Cansu Uzner is an Obstetrician and Gynaecologist currently working as a Staff Specialist and Co-lead of Early Pregnancy Assessment and Acute Gynaecology Service at Nepean Hospital. She obtained her FRANZCOG after completing a two-year Gynaecology Fellowship of Gynaecological Ultrasound and Laparoscopic Surgery Endometriosis at Nepean Hospital and undertaking her RANZCOG Core Training through the Royal North Shore Hospital. She is a member of AGES, ISUOG and ASUM and is currently completing her DDU (Diploma of Diagnostic Ultrasound). Her special interests in research are gynaecological ultrasound, endometriosis, and early pregnancy complications. She has been involved in multiple research studies including the International Deep Endometriosis Analysis (IDEA) terminology validation pilot study.

# Editorial



**Dr Nisha Khot**  
MBBS, MD, FRCOG, AFRACMA, FRANZCOG

The birth of a child is a momentous and memorable occasion for any parent. In recent years, there has been increasing recognition of how birth experiences can trigger physical and psychological distress with profound, long-term consequences. This year, two significant enquiries into birth trauma were published. The first was from the UK, titled: "Listen to Mums: Ending the postcode lottery in perinatal care". The second, closer to home, was the NSW Parliament Legislative Council Select Committee on Birth Trauma report 1. Both reports highlighted the importance of better education for women on birth choices and support for maternity care providers to undertake training in informed consent.

Furthermore, a survey by Australasian Birth Trauma Association revealed 1 in 3 birthing parents agreed to birth interventions without fully understanding the risks. This issue of the O&G magazine has been in planning for some time. It seemed opportune to explore informed birth in light of increasing evidence of the urgent need for informed, structured discussions prior to birth.

At the core of informed birth is respect for a woman's autonomy and her right to make decisions about her own body and her birth. This requires a shift from a paternalistic healthcare model to one that is woman-centred and collaborative. Central to this is the provision of accurate, evidence-based, comprehensive, unbiased information in easy-to-understand language. It also includes providing detailed information where there is a lack of evidence for a particular intervention or course of action.

As healthcare providers, we play a pivotal role in promoting informed birth. If we are to do our job as educators, we need training not only in the technical aspects of childbirth, but also in effective communication and cultural competence. Having provided the information and listened to women's concerns, we must create opportunities for ongoing dialogue. The challenge we face in practice is our duty to continue to provide care and support women's choices when they differ from standard practices and guidelines. Negotiating these differences requires relationship building, creating trust between the woman and her healthcare provider. I am reminded of the words of a pregnant woman I recently cared for who thanked me for treating her 'like a whole person, not just a collection of risk factors'.

Informed birth should not be just a lofty ideal; it should be a practical and achievable goal that can transform the childbirth experience for women everywhere. By empowering women with knowledge and supporting their choices, we can create a more respectful, safe, and positive birth experience. Whether the choice an individual woman makes is that of a caesarean birth at maternal request or a birth with no intervention, both are equally deserving of support, with appropriate counselling. The time for action is now. I hope this issue will help us make informed birth a cornerstone of maternity care in Australia and Aotearoa New Zealand.



# The importance of informed birth

## Why it matters for clinicians & parents



### Amy Dawes

CEO and Co-founder, Australasian Birth Trauma Association (ABTA)

At the Australasian Birth Trauma Association (ABTA), we recognise that childbirth is a monumental event in parents' lives. However, when trauma occurs, its impact can extend far beyond the early stages of parenthood. We can ensure clinicians understand the importance of informed birthing and parents are well-informed about the birthing process, both being crucial steps for promoting positive birth outcomes and minimising birth-related trauma.

In June 2024, ABTA conducted a survey of the general population, which received 1,005 responses. Nearly all participants identified as female (99.9% female, 0.1% non-binary), were between 18 and 45-years old and had given birth in the past five years. The respondents were evenly distributed across all Australian states and territories, including both metropolitan and regional areas. Our survey found that one in three (36%) birthing parents in Australia agreed to birth interventions without fully understanding the risks involved.

This lack of information often means parents are unable to make fully informed decisions about their childbirth options. Informed consent, or the lack thereof, is a significant contributing factor to birth-related trauma. Feeling informed goes beyond having access to information; it involves feeling heard, listened to, and empowered to ask all the necessary questions to make informed decisions.

### Bridging the information gap

Our experience working with parents over the past eight years has shown that women and their families want to be as informed as possible before giving birth, understanding all the options and risks. Despite this clear demand, there is a significant gap in the information provided to parents about potential complications and outcomes. Our survey showed only 34% of healthcare professionals discussed pelvic organ prolapse or nerve damage with parents before birth. Similarly, only 43% addressed concerns like urinary, fecal, or wind incontinence and severe tears (third or fourth degree). This lack of comprehensive information can leave parents unprepared for the realities of childbirth and its potential consequences. Additionally, without clear postnatal care pathways, this leaves parents to shoulder the burden of finding the right care for their needs, often resulting in thousands of dollars of out-of-pocket expenses.

### The impact of birth-related trauma

ABTA's 2022 research report 'Birth Injuries: A Hidden Epidemic' highlighted the devastating effects that birth-related conditions can have on parents' lives. Pelvic organ prolapse, incontinence, and severe tears can lead to significant physical and emotional distress. Without access to evidence-based education and true informed consent, parents may find themselves overwhelmed and unsupported when faced with these challenges, bearing the toll of seeking specific support for their unique needs.

### The role of clinicians

Healthcare professionals play a crucial role in closing the information gap about the potential consequences of childbirth. When exploring birth options, our survey participants ranked their key sources of information about birthing topics. The top five sources included friends and family, obstetricians, Google, GPs, and hospital birthing classes.

Despite the availability of various information sources, only half of the parents participated in antenatal education or birthing classes before giving birth. Among those who did not attend these classes, 17% conducted their own research, and 15% indicated that their hospital or care provider did not offer any classes. This highlights a significant reliance on unsubstantiated sources for vital birthing information.

As one survey respondent noted, "In my birth class, they didn't talk about forceps as they said they didn't really use them anymore and said the resuscitation bay was just where they kept their notes. My baby needed forceps and resuscitation. With one in three births being considered traumatic, we really need to let go of the idea of worrying women about labour. Women deserve to have knowledge, and maybe that would reduce the trauma experienced by so many."

The majority of our survey respondents supported expanding the breadth and depth of, and access to, evidence-based antenatal birthing education. This includes multidisciplinary input (doctors, pelvic physiotherapists, lactation consultants) and the implementation of written informed consent in the third trimester in collaboration with

midwifery or obstetric staff. This is a critical consideration when so many women rely on Google for their information.

### Supporting informed birth: How clinicians can help

By providing balanced, evidence-based, and reliable information, clinicians can empower parents to make informed decisions about their childbirth options and go a long way toward addressing preventable birth-related trauma. Here are some ways clinicians can support informed birth:

- **Provide comprehensive information:** Discuss the benefits and potential risks of different birth options and procedures before the birth. Ensure parents understand the full spectrum of possibilities.
- **Enhance understanding:** Offer easy-to-read materials and translation services as needed. Utilise resources from the Australasian Birth Trauma Association to facilitate understanding.
- **Encourage questions:** Create a supportive environment where parents feel comfortable asking questions. Avoid medical jargon and appreciate decision-making is a continuous process.
- **Respect parental choices:** Act on the decisions made by parents and respect their wishes. Always seek consent before providing care, remember that consent is a process and make referrals to specialists when necessary.

As one parent shared: "I think it would be good to know a little about the potential complications but include absolute risk so people can understand how unlikely they are. What I really think is missing from birth education, in general, is consent, complications that interventions can bring about, and what to expect in/after an emergency cesarean. My first birth class focused on natural birth, but due to the cascade of interventions, I ended up with a cesarean, and I was surprised to learn I would still bleed from my vagina afterwards. Sounds basic to me now, but I had no idea the bleeding was from where the placenta detaches."

### Creating a positive childbirth experience for all

Informed birth education is essential for both clinicians and parents. Working together to ensure comprehensive, balanced, and accessible information, we can create a more positive and empowering childbirth experience for all. It is vital that the preferences of the mother, whether she desires an elective cesarean or a home birth, are supported and respected. There is no risk-free birth route, and discussing and respecting an individual's personal risk profile and preferences is so important. Providing information and education without withholding details out of concern for causing fear is essential. Empowering women through the provision of information is crucial in shaping their experience of pregnancy, childbirth, and beyond.

At the Australasian Birth Trauma Association, we are deeply committed to supporting healthcare professionals in their work. To learn more about our training and resources, including our new ThinkNatal educational resources and CPD training modules, visit: [birthtrauma.org.au/health-professional](http://birthtrauma.org.au/health-professional).

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# Birthing in the age of social media



**Dr Katie Ryan**  
MBBS, M WomHMed, FRANZCOG Trainee

Over the last few years there has been a sharp increase in the level of media attention on pregnancy and childbirth, and more specifically, the voices and experiences of mothers. Naturally, Australia's maternity services have come into focus in a big way. In November 2022, the ABC News network launched The Birth Project, a year-long "quest to explore childbirth (and beyond) in Australia".<sup>1</sup> This has served as a catalyst for a steady flow of articles highlighting the rising rate of intervention, birth trauma and by association, the wave of interest in freebirth.

The following year, the NSW Parliament launched an inquiry into birth trauma. This cast a wide and public spotlight on the very real, relatable and in some cases devastating experiences of birthing mothers across the state. This also happened to be the year that I was working as an unaccredited obstetrics registrar in Sydney, anxiously preparing for my upcoming interview to be accepted onto the RANZCOG training program.

Fast forward to early 2024, and I was thrilled to begin my journey as an accredited trainee. Three months into my training, the recommendations from the birth trauma inquiry were released. Safe to say, it has been an interesting time to be immersed in the birth world. The findings and recommendations of the inquiry have sparked many conversations among my peers about the rewarding, yet challenging and often raw profession that is obstetrics.

One theme that continues to emerge in discussions is the role of social media. A few years ago, Instagram may not have been considered relevant in the broader conversation of childbirth, maternity care and birth trauma. But somewhere along the line, social media evolved beyond selfies to serve as a powerful platform for the dissemination of health information. In the context of childbirth, we can't deny the influence of social media on education and decision making.

Perhaps this was an inevitable evolution, however COVID-19 and the events of 2020 undeniably played a role. As the COVID-19 pandemic took hold, I was in my intern year, the world was locked down and as healthcare workers, we faced the brunt of its effects. Women were birthing in isolation, without receiving basic antenatal education and were confronted with the need to make decisions among a rise in vaccine hesitancy, all while navigating the very valid fear of becoming unwell with COVID-19 during pregnancy.



It was during this time that Instagram pages such as “Birth with Beth” were created. Many health professionals who were navigating this climate of immense uncertainty saw a desperate need for publicly available, free and evidence-based birth education. Beth Ryan, the founder of this page is a registered midwife with a Masters of Public Health. Five years on, her page has amassed a following of over 47,000 people who engage with her educational content on a daily basis. But Beth is certainly not alone. The post COVID-19 era has seen a steep rise in the number of accounts offering up information and women’s health is a *hot* topic.

So, what does it mean for our patients and birthing-parents to consume platforms like Instagram and Tik-Tok that are both extremely influential and largely unregulated?



It’s a question well worth considering and one that was explored by a 2023 Queensland-based systematic review.<sup>2</sup> The review endeavoured to better understand the impact on birthing parents utilising social media in a time of heightened vulnerability to influence. More specifically, it homed in on the impact of following social media ‘influencers’ and ‘bloggers’ who specifically generate content relating to pregnancy, birth and early parenting.

Clear benefits were identified, namely those relating to the increased ability to connect with others during a season of life that can feel isolating. One study reported that over 83% of people surveyed considered their social media “friends” a source of support in motherhood. Equally however, the potential harms of misinformation and monetisation were demonstrated. Influencers hold unique power whereby, unlike registered health professionals, they are free to express their views and perspectives relating to health without ethical or legal ramifications.

This presents an extremely challenging online environment for both parents and health professionals alike. Traditionally, the birth education space was dominated by healthcare practitioners. Now, anyone with an account can disseminate health information. While this (understandably) sounds frightening, it is also worth interrogating the lack of evolution in the way education is delivered in mainstream antenatal settings.

The question must be asked: Is the way that we deliver education in public maternity services outdated?

Women are provided with print flyers, expected to read posters in waiting rooms and invited to join group Zoom calls, when in reality; it is more convenient and enticing to absorb information in the form of snappy social media posts, short-form video and digital courses. But the issue remains, where accuracy and a lack of nuance continues to be at the heart of this challenge.

Rising interest in the freebirth movement serves as a powerful example of the way in which social media can influence the culture around childbirth. In a recent ABC article *The Price of Freebirth*, Professor Hannah Dahlen, Australia’s leading midwifery researcher quite aptly described the dichotomy between hospital-based obstetric care and the freebirth movement as a “massive chasm between two imperfect worlds.”<sup>3</sup> A chasm, we see stretched even further by conflicting information presented on social media.

The very nature of social media requires information to be flattened. 30-second videos and strict word limits lend themselves to the rise of black and white statements. The allure of ‘engagement’ also encourages creators to publish emotive content that snags the attention of their followers. When you have a topic as varied and complex and childbirth, this is a major issue. This point feels particularly challenging because as O&G registrars a large part of our role is to present up-to-date information in a way that is accessible and support women to make individualised and informed choices. But rather than feeling challenged, particularly by social accounts that offer vastly different perspectives from our own, perhaps we should take this crucial opportunity to reflect on our own role in the conversation.

The issues explored here are big, blurry and they are not going to resolve any time soon. But they do deserve our consideration and thankfully, we have colleagues dedicating time and research into the topic. To finish off, I leave you with two questions that continue to come up for me and for my peers:

As maternity providers, do we have a responsibility to evolve and stop treating social media as something to be cautious of?

Should we accept that social media has become an accessible and therefore integral part of health education and be more proactive in joining the chorus of voices in an effort to balance misinformation online?

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# Our responsibility to inform, the mother's right to decide

## Informed care in midwifery continuity



**Betty Holland**  
Clinical Midwifery Specialist 2

Continuity of Midwifery care (CoC) is widely recognised as the 'gold standard' of maternity care for women. The updated 2024 Cochrane review found CoC increases rates of spontaneous vaginal birth and decreases rates of instrumental and caesarean births, as well as more positive experiences throughout the pregnancy, labour, and postpartum continuum.<sup>1</sup>

A context of relationship-based CoC allows for a unique trust to evolve over the pregnancy between a woman and her midwife. There is an investment in the journey, experience and outcome for this woman and her family from the perspective of the midwife, and with that comes very deep reward and satisfaction, but it does not come without its challenges.

The 2023 Birth Experience Study explored women's experiences of birth in Australia over the past five years.<sup>2</sup> This is an important and relevant topic, particularly with the recent NSW Birth Trauma Enquiry. This study, along with the Birth Trauma report<sup>3</sup> found that women, across models of care, desire *relational maternity care founded on their unique needs, wishes & values*. Undoubtedly, the limitations of time, system and staffing of the current mainstream maternity care impede on our ability to provide this.

As a result, many women who make decisions outside of typical maternity guidelines and recommendations seek their maternity care within a continuity model. In this context they can build rapport with their midwife, have meaningful discussions including sharing of evidence-based information, and know they are able to make their own informed decision and have it heard and respected.

The Queensland Health guideline: "Partnering with the woman who declines recommended maternity care" includes flowcharts for discussion, documentation, and escalation for women declining recommendations, but the core underpinning conclusion of the guideline is that: "*The woman continues to receive care within the parameters of her consent*".<sup>4</sup> Though our team firmly believes in this principle, this partnership and responsibility of caring for those who go "against the status quo" is a large workload that falls largely on continuity midwives.

We are incredibly fortunate in the Caseload Midwifery program at Westmead Hospital to work highly collaboratively with our obstetric specialists. Our midwives each have a consultant they meet with weekly to consult and discuss their caseloads. This provides an extraordinary opportunity for learning for midwives and doctors alike who each learn to trust each other and work cohesively to deliver safe care that is centred around the woman's individual needs.

Sometimes medical recommendations, while evidence-based and aimed to ensure the best possible outcome, are not accepted by the woman. The role of medical and midwifery staff is to appropriately counsel and inform the woman of the evidence, risks and benefits. Their role is not to make any decisions for her or coerce her into making the decision they feel most comfortable with. This can undoubtedly cause fear and anxiety for her care-providers, but our discomfort does not outweigh her right to autonomy to make her own informed decision.

*Adjacent Image: Betty Holland auscultating the fetal heart rate during caseload client Andrea's labour (Westmead Hospital, Sydney). Photo credit: Alisia Mason Photography*







*Pictured: Betty Holland with caseload client Andrea and her Husband Andrew in the Birth Unit at Westmead Hospital, Sydney. Photo credit: Alisia Mason Photography*

According to the 2019 Human Rights in Childbirth Submission to the Australian Human Rights Commission: "Full and informed consent is only given if the healthcare provider explains the health status of the woman and her fetus, and provides complete and unbiased evidence-based information regarding her healthcare options and its risks. It includes the option to decline treatment. The woman should be given time, without pressure, to consider her options and decide independently of any influence and she has the right to change her mind at any time. Despite the ethical and legal obligations of facility-based healthcare providers to obtain full and informed consent to medical procedures, it is rarely observed in practice in maternal health. We have found, in our work, that informed consent is not standard practice, and worse, women who attempt to refuse medical treatment are often badgered or bullied and some forced against their will to undergo procedures, including surgical interventions of their bodies".<sup>5</sup> This sentiment was echoed in the Birth Trauma Report following the parliamentary inquiry.

Take, for example, a woman who has had a previous 3B tear. The caseload midwife discusses the case with her consultant at their weekly sit-down consult meeting. Together they review the notes, the woman's endoanal ultrasound and her current symptoms. The consultant recommends that if she wants another vaginal birth, she has an elective episiotomy to minimise the risk of a recurring major tear. The midwife discusses this with the woman - presenting evidence and a discussion of the risks and benefits of an elective episiotomy or another major tear. She declines an elective episiotomy antenatally, sees the consultant at 36-weeks for another mode of delivery discussion, where she is appropriately counselled again, and again declines. During labour, her midwife is already aware of her birth choices and preferences and the fact that she has not consented to an elective episiotomy unless it is otherwise indicated at the time of birth.

Perhaps this woman has an intact perineum following this birth, aided by the weeks of perineal massage she has done to familiarise herself with the sensation of crowning, or the trust-based communication between midwife and woman to control the slow birthing of the head. Or, perhaps, she has another third-degree tear requiring transfer to OT for repair, physiotherapy follow up and known possible long-term implications to her health.

Regardless of the outcome, this woman was appropriately informed of the risks and was listened to and trusted by her midwife. Her outcome, which to her care providers was not the desired outcome, was for her incredibly positive and un-traumatic. We must trust that while we have a high level of medical expertise, women should always be the experts of their own bodies, pregnancies and births. They are not ours to control - regardless of outcome.

Another example from my own professional career as a caseload midwife was a growth-restricted baby whose mother was declining an induction of labour. While we may not have agreed with her decision ourselves, my obstetric consultant and I worked together to share information and counsel this woman appropriately.

This involved negotiation around timing of birth; asking about an end-point for when the woman might consider an IOL and answering questions about alternative plans for monitoring. In this case, the woman felt incredibly convicted that she felt her baby was safe and needed more time in-utero and was very reassured by a consistent pattern of fetal movements. While I certainly might have slept better if I knew this baby was safely born earlier (since the EFW and AC measurements were each on the second centile and her fundal heights were also measuring concerningly less than gestational age), she felt comfortable having second daily CTGs, her weekly doppler studies were normal and her baby was moving according to their normal pattern.

While the responsibility for the wellbeing of this baby was not wholly on my shoulders, as the lead maternity carer in a CoC context we must be mindful of the weight of carrying these cases. Although we may believe in a woman's right to make an informed decision, this does not prevent our fear of the worst outcomes in pregnancy, labour and birth, including the fear of litigation. Extensive discussion and support within my caseload team and utilisation of clinical supervision for debriefing were incredibly important for my personal and professional wellbeing when caring for women who were straying from medical recommendation.

In this case, after the initial recommendation by MFM to induce by 38 weeks, she spontaneously laboured at 40 weeks and had an uneventful birth of a very tiny but otherwise well baby, born on the second centile as predicted.

While this outcome could easily have been different for another case, woman, baby and midwife, our job is to inform of evidence, risks, benefits, recommendations, and alternatives. After hearing these things, clarifying preferences and asking necessary follow-up questions it is the woman's choice to decide. We must then hear her decision and respect it. This is by no means easy, but particularly in a context of relationship-based care; and often in a context of previous birth-related trauma – this is always our role and responsibility.

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# Placing the mother at the heart of decision making



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Informed birth requires expectant mothers to receive clear and understandable information from healthcare providers about childbirth options and preferences. This enables them to actively engage in shared decision-making, thereby playing an active role in shaping their birthing experience.

To provide informed consent for obstetric patients we must navigate several concepts including bodily autonomy, birth philosophy, temporal decision-making, and our own biases when confronting risk and uncertainty. For both expectant mothers and their healthcare providers, managing this process requires more than medical expertise — it demands kindness and respect.

## Managing risk in childbirth

In obstetrics acknowledging bodily autonomy, respects a woman's right to make decisions about her body and health. This principle underpins informed birth, empowering women to choose their childbirth journey based on personal values and aspirations for motherhood. Alongside autonomy, societal ideals of performing "good motherhood" and confronting risk, add layers of complexity. Expectant mothers often navigate personal desires alongside cultural norms and societal and family members' expectations.

There is no doubt that the remarkable success of modern obstetrics in reducing mortality from childbirth is based on the founding principle of identifying and managing risk. The dramatic improvement in birth morbidity and mortality seen in the 20th century occurred as interventions were introduced: standardised antenatal care, moving birth into hospitals, as well as implementing lifesaving interventions with medications, aseptic conditions and operative births. This proactive, rather than reactive, approach to risk has defined modern obstetric care ever since.

There are concerns now that in well-resourced countries like Australia, the pendulum has swung too far. Has our emphasis on reducing morbidity resulted in a system so risk averse, that it has impacted the agency of expecting mothers? Some of the overarching themes that led to the recent NSW Inquiry into Birth Trauma, arose from concerns that in current maternity care provision, "informed consent was not a priority", and that the "focus was solely on the result of the birth and did not consider the health or the birthing experience of the mother".<sup>1</sup>

Managing risk in childbirth has resulted in the development of two major groups of "birth philosophy". One perspective focuses on risk and potential morbidity. From this viewpoint, opting for anything other than standard hospital-based medical care might be perceived as unconventional or harmful. Conversely, women who view pregnancy as a natural process see "alternative" options as opportunities to maintain their bodily autonomy and view the praxis of modern medicine as a departure from how an organic experience birthing should be.<sup>2</sup> The potential clash between these two philosophies runs the risk of marginalising women in our society who have developed a mistrust of standard obstetric care practices, resulting in the free birthing movement and an even greater potential for harm.

Ultimately, while childbirth has been a physiological process for women for the last several thousand years, it unquestionably carries inherent risks. Modern society now is far less tolerant of adverse outcomes which were historically accepted in the process of birth. How people respond to uncertainty varies and is shaped by a complex interplay of influences rather than from rational assessments of risk. Given the same information, individuals are bound to make different choices to achieve a sense of control. The same applies to informed birth, where choices, are strongly influenced by temporal factors. As humans we desire for information to be confirmed by the force of experience. Experiences like previous birth, significant life events, the history of family and friends, as well as events during the pregnancy. These memories of trauma, loss, and happiness profoundly shape decision-making approaches.

## Building trust

The role of an Obstetrician in advising expectant mothers in decision making, relies not only on an understanding of her experiences and the impact this has on her choices, but also on building trust. Trust can be difficult to establish, particularly in the practice of modern obstetrics with fragmented approaches to care and lack of continuity. Expectant mothers are now siphoned into low and high-risk models of care at the start of pregnancy. As risk changes or escalates in pregnancy, expectant mothers can be rapidly confronted with decisions around previously unforeseen issues, by obstetricians who they may be meeting for the first time and with whom they have not had chance to build trust or a rapport with.



We run a public clinic, catering to women with a breech baby at term. We provide an opportunity to discuss mode of delivery options and to facilitate a planned vaginal birth if the woman makes that choice. The primary aim of this clinic is to enable women to receive evidence-based information and non-directive counselling regarding their options, which responds to their values and feelings and supports them to come to a decision which makes them feel safe and understood.

*"It is important to acknowledge, that while patient autonomy is crucial, its increasing emphasis can lead to harm when difficult decisions lack expert guidance."*

A great deal of the consultation is spent getting to know the woman and understanding her birth philosophy. We reflect this knowledge in the counselling she is provided. This is done, by asking open-ended questions at the start of the consultation and understanding her plans for birth prior to finding out her baby was breech. Furthermore, we seek to understand what her wishes are from the visit. Ideally, the first few minutes of the consultation are spent with the expectant mother talking, and the clinicians listening and gaining insight into her values and philosophy.



An essential part of the visit also involves deconstructing the sometimes-overwhelming number of decisions to be made. In the case of our breech clinic, this involves a discussion of the first decision to be taken – whether a patient is going to proceed with an external cephalic version (ECV), which as per NSW Health policy should be offered by all maternity services. Only if the ECV is declined or fails, do we proceed to a discussion of the options for a planned vaginal breech birth versus a planned caesarean section. Otherwise, an overload of information can make it more difficult for women to prioritise their choices, hindering their ability to give informed consent. Wherever possible, we also try to allow women time to come to decisions without applying undue pressure and reaffirming our belief that we trust her to make her own decision. In our experience, the simple acknowledgment of this fact frequently opens her up to asking for our advice and trusting our line of counselling.

Another important facet of establishing trust hinges on our presentation and comfort with risk. Planned vaginal breech birth is no longer available at most maternity services in Australia. We acknowledge the particular and specific risks of a vaginal breech birth compared to an elective caesarean is an essential component of the counselling. The information is presented and discussed in a manner which doesn't pre-empt a decision. This is essential in respecting women's autonomy and decision-making capacity. We prefer to present absolute risk rather than the relative risk of adverse outcomes when discussing the potential for harm. We specifically reassure the woman that by far the most likely outcome of whatever decision she makes is a healthy mother and baby and that we will respect and provide care to support her. Once trust is established in this manner, patients are far more likely to appreciate guidance if it is required.

It is important to acknowledge, that while patient autonomy is crucial, its increasing emphasis can lead to harm when difficult decisions lack expert guidance. Simply providing information on childbirth options, procedures, risks, and benefits can neglect the potential for a meaningful patient-physician relationship. The value of an obstetrician in guiding decision-making relies not only on their knowledge and counselling skills but also on their compassion and empathy. Early in my training, I witnessed a senior obstetrician advising a couple facing the agonising decision of delivering twins at a peri-viable gestational age. He offered to make the decision for them if they couldn't, a gesture of kindness and empathy that profoundly shaped my approach to patient care. In his essay *Whose body is it anyway* Atul Gawande asserts that "the real task isn't to banish paternalism; the real task is to preserve kindness".<sup>3</sup>

In obstetrics, navigating the complexities of childbirth involves more than medical expertise alone –it demands kindness, respect for autonomy, and the cultivation of trust. Achieving informed birth requires balancing medical knowledge with understanding individual values. Creating a supportive environment where expectant mothers feel empowered to make decisions based on clear information is crucial. This compassionate approach not only enhances the birthing experience but also fosters a relationship of trust and mutual respect between clinicians and patients.

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# CAPEA: Preparing parents for childbirth and parenting



## Bithia O'Brien

CAPEA Liaison for International Journal of Birth and Parenting Education

Childbirth and Parenting Educators of Australia (CAPEA) is a voluntary, professional association that supports Childbirth and Parenting Educators. Each year, CAPEA members work with their health colleagues to prepare parents for childbirth and parenting.

In the 1930s and 1940s, interest in natural childbirth grew through the popular work of Obstetricians Grantly Dick-Read and Ferdinand Lamaze, which were based on Pavlov's theory of the 'conditioned response'<sup>2</sup>. It was around this time that physiotherapists began to provide prenatal "training for childbirth"<sup>3</sup>.

Growing in popularity in the 1950s, antenatal education was formalised and held in a group setting taught by health professionals. The focus was the perceived needs of the woman to prepare for physiological labour and a hospital birth. In 1965, the Bradley method "Husband-Coached Childbirth" encouraged male partners to provide support for their partner during the labour<sup>4</sup> and fathers were encouraged to be present for their child's hospital birth.

Modern Western parent education promotes the support person to be an active participant/parent, as younger generations are expecting equity within the home and in parental roles<sup>5</sup>. Antenatal education is now available for tailored groups, for instance dads only, CALD and LGBTIQ+ communities.

The COVID-19 pandemic provided an opportunity to diversify the formats, resources, skills and technology used in providing education online. These are examples of how antenatal educators adapt content, format and resources to provide psychological safety in a group setting to foster a positive adult learning environment.

Antenatal education has become a normalised part of "having a baby in Australia". It is promoted as increasing parental confidence, self-efficacy, parenting skills and knowledge. Parents are asking for more focus on preparation for parenthood, in a format that works for them<sup>6</sup>. The newest parents, the digital natives, gather information differently to previous generations and may rely on popular opinion that is presented as fact<sup>7</sup>.

## Criticisms of antenatal education have included:

- A lack of evidence about its efficacy in birth outcomes
- Lack of consideration of adult learning principles<sup>8</sup>
- An increasing focus on hospital policy/intervention in labour and birth rather than the participants needs<sup>9</sup>
- Commercialisation of antenatal education
- Concerns about the quality and lack of standardisation of content, and a lack of rigorous oversight.
- In Australia, there are no standards or qualifications required for antenatal educators or antenatal education programs<sup>10</sup>.

Recent studies show that antenatal education can change birth outcomes. Women whose antenatal education included psychoprophylaxis had higher rates of vaginal birth rates<sup>11</sup>.

In 2024, antenatal education is primary health care. Knowledge and discussion around preconception care for both men and women are gaining momentum, as we learn more about epigenetics. An infant's growth, development, and mental health benefit when we support all families, but when we provide additional targeted support to priority populations, children thrive<sup>12</sup>.

We know that the intrauterine and extrauterine environment can shape a baby's growing brain and life-long health. Antenatal education is changing how we talk about infant growth and development<sup>13</sup>. We reframe how we talk about parenting, focusing on children and supporting parents because we know this is the language that can shift mindsets<sup>14</sup>.

As antenatal educators we are health literacy translators. Health literacy is how people access, understand and use health information in ways that benefit their health. It can be affected by an individual's age, education, disability, culture, and language. It affects a family's capacity to make informed decisions<sup>15</sup>. Informed decision-making skills are a prerequisite to giving informed consent.

## For there to be valid informed consent, the person consenting must:

- Have the legal capacity to consent
- Give their consent voluntarily
- Give their consent to the specific treatment, procedure

or other intervention being discussed

- Have enough information about their condition, treatment options, the benefits and risks relevant to them, and alternative options for them to make an informed decision to consent. This includes the opportunity to ask questions and discuss concerns<sup>16</sup>.

Examples of this are the Third- and Fourth-Degree Perineal Tears Clinical Care Standard | Australian Commission on Safety and Quality in Health Care<sup>17</sup> and Stillbirth Clinical Care Standard (2022) | Australian Commission on Safety and Quality in Health Care<sup>18</sup>. Both standards are about challenging topics. Historically, both topics might not have been included in an antenatal education program for fear of upsetting the birthing families. Both standards identify that information should be provided and discussed antenatally.

This allows women and their families time to consider both the risks and benefits involved, and the evidence-based care and skills that can be provided to reduce her risk; for example, perineal massage and warm compressors during second stage to decrease the risk of 3rd and 4th degree tears, smoking cessation and being aware of her baby's normal fetal movements to reduce the risk of stillbirth. This process facilitates individualised informed decision making so that the woman can decide whether to provide informed consent (or not) for the care she is offered.

Epidural analgesia, induction, instrumental and Caesarean birth rates are increasing. These medical procedures require informed consent. How do we work together with our medical colleagues to help our families become informed, so that when consent is given, it is truly informed consent? The answer is partnership, with our consumers and our colleagues<sup>19</sup>.

The recent NSW Senate inquiry into Birth Trauma recommends: "NSW Government develop minimum standards for and ensure access to comprehensive evidence-based antenatal education for birthing and non-birthing parents covering all aspects of birth, including different models of maternity care, potential interventions, and their rights during the birthing process. This education should be made available in a variety of modalities and in a form that is accessible to culturally and linguistically diverse communities"<sup>20</sup>.

**For more information on CAPEA visit: [capea.org.au](http://capea.org.au)**

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# Informed choice in reproductive genetic screening



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Reproductive genetic screening can promote reproductive autonomy by providing people with information to support informed decision making around future or current pregnancies. There are a variety of reproductive genetic screening options available for people to consider, which can determine their chance of conceiving a pregnancy with a chromosomal or inherited genetic condition. These include prenatal screening for chromosome conditions such as Down syndrome (trisomy 21, or T21) via maternal serum screening or cell free DNA (cfDNA) screening (also known as non-invasive prenatal testing, or NIPT), and preconception or prenatal carrier screening for autosomal recessive and X-linked inherited genetic conditions. With many different pathology providers offering similar but subtly different screening options, it can be challenging for prospective parents to decide what, if any, screening to choose.

## What reproductive genetic screening tests are available?

Reproductive genetic screening options include (see Table 1 for more detail):

### 1. Aneuploidy screening during pregnancy

- Maternal serum screening (MSS)
  - First trimester MSS (also called combined first trimester screening) uses a combination of two blood markers, ultrasound measurements and maternal factors to determine the chance of the common trisomies T21, T18 and T13 in a pregnancy.
  - Second trimester MSS uses four blood markers and maternal factors to determine the chance of T21, T18 and neural tube defects in a pregnancy.
- cfDNA screening utilises placental cfDNA in the maternal bloodstream to screen for aneuploidy, which can include the common trisomies, sex chromosome aneuploidy (and fetal sex), rare autosomal aneuploidy, large segmental chromosome imbalances and in some cases microdeletions, depending on the technology used.

### 2. Reproductive genetic carrier screening

- Three condition carrier testing screens the female reproductive partner for carrier status for cystic fibrosis (CF), spinal muscular atrophy (SMA) and fragile X syndrome (FXS). If the female carries CF and/or SMA, the male reproductive partner is offered testing for the relevant condition/s.
- Large panel carrier testing screens for hundreds of autosomal recessive conditions, and X-linked conditions. Some large panel test providers report individual carrier status, whereas other providers produce a combined couple result, reporting if both reproductive partners carry the same autosomal recessive condition/s, or if the female carries an X-linked condition. When screening for hundreds of conditions, most people screened will be a carrier for one or more condition, thus it is practicable to screen both members of the reproductive couple at the same time.

## Who should be offered reproductive genetic screening?

The 2018 RANZCOG Statement Prenatal screening and diagnostic testing for fetal chromosomal and genetic conditions<sup>1</sup> recommends that “all pregnant women should be provided with information and have timely access to screening tests for fetal chromosome and genetic conditions”. A common misconception is that genetic carrier screening is only relevant to people with a family history of a genetic condition. However, for women screened for CF, SMA and FXS, 90% of those identified as carriers had no family history of the condition.<sup>2</sup> The 2019 RANZCOG Statement on Genetic carrier screening<sup>3</sup> recommends that “information on carrier screening for other genetic conditions should be offered to all women planning a pregnancy or in the first trimester of pregnancy. Options for carrier screening include screening with a panel for a limited selection of the most frequent conditions (e.g. cystic fibrosis, spinal muscular atrophy and fragile X syndrome) or screening with an expanded panel that contains many disorders (up to hundreds)”.

Test	Conditions Screened	Cost	Logistics
<b>Maternal serum screening</b>	First trimester combined screening: T21, T18 and T13. In Australia, can include screening for early-onset pre-eclampsia (EO-PE)	Australia: blood test has partial Medicare rebate, may be cost for ultrasound. Aotearoa/New Zealand: blood test is free, may be cost for ultrasound	Blood sample from 9+0 to 13+6 (earliest blood for EO-PE screening 11+0), ultrasound from 11+1 to 13+6
	Second trimester serum screening: T21 and T18, and also neural tube defects in Australia	Australia: full or partial Medicare rebate. Aotearoa/New Zealand: blood test is free	Blood sample from 14+0 to 20+6
<b>cfDNA screening</b>	Varies according to provider, all include T21, T18 and T13, some include sex chromosome analysis as routine, others as "opt-in". Some providers screen all chromosomes including large segmental DNA changes, and/or a small number of microdeletions.	Australia: generally patient funded, some services may fund for some patient circumstances. Aotearoa/New Zealand: Some public hospitals fund contingent cfDNA screening after a high chance MSS result. Otherwise, patient funded	Blood sample from 10+0. Result available in 3-7 days
<b>Genetic carrier screening</b>	Three condition screen: cystic fibrosis, spinal muscular atrophy and fragile X syndrome	Australia: funded by Medicare since Nov 2023. Aotearoa/New Zealand: patient funded	Sequential testing, female partner tested first, if carries CF or SMA, male partner tested. Blood or saliva sample, ideally preconception, otherwise preferably before 12 weeks gestation. Result available in 2-3 weeks
	Expanded or large panel carrier screening: several hundred to >1000 genes, depending on provider	Australia: Medicare rebate for 3-condition component of test, out-of-pocket cost for remainder of test. Aotearoa/New Zealand: patient funded	Testing of both reproductive partners at the same time is recommended. Blood or saliva sample, ideally preconception, otherwise before 12 weeks gestation. Result available in 6-8 weeks

Table 1. Reproductive genetic screening tests

## Informed choice – what do people need to know about genetic screening tests?

In developing a measure of informed choice regarding screening tests offered in pregnancy, Marteau *et al*<sup>4</sup> defined informed choice as “one that is based on relevant knowledge, consistent with the decision-maker’s values and behaviourally implemented”. Van den Berg *et al*<sup>5</sup> later expanded the concept of informed choice to informed decision-making and emphasised that the decision should involve a process of deliberation. Not only is it ethical practice to ensure patients are informed of the purpose, benefits and limitations of screening tests, studies show that informed choice is associated with better patient outcomes and less decisional regret.<sup>6</sup> Rather than solely providing information about genetic screening tests, healthcare providers should support patient decision-making that is consistent with the patient’s personal values.<sup>7</sup>

Ormond *et al*<sup>8</sup> have developed a list of critical components for informed consent for genetic testing which are applicable to reproductive genetic screening. The components provide a guide for health practitioners to facilitate a discussion with their patients around informed choices about genetic screening and testing. The following points should be covered in pre-test counselling:



- 1. Patients should be aware that deciding not to have screening is a valid choice.** There are concerns around possible routinisation of testing such as cfDNA screening, in that it may be seen as “just another blood test” if it is offered without appropriate pre-test counselling.<sup>9</sup> It is important that patients are aware that results from such screening could have important unexpected implications for their pregnancy, such as the potential for the offer of pregnancy termination if a chromosomal or genetic condition is diagnosed. People should be provided with sufficient time to make an informed decision about genetic screening tests.
- 2. Information regarding the purpose of screening tests,** including why the test is done and what conditions, or types of conditions, the test does (and doesn’t) screen for. As testing becomes more complex with many more conditions able to be screened (e.g. whole genome cfDNA screening, large carrier screening panels), it is impossible to discuss every condition being screened. It is reasonable to provide an overview of the types of conditions screened, and to provide people with written or online resources should they wish to explore these in more detail. An explanation of test sensitivity and specificity can be helpful, as well as stating the limitation that no test can detect every possible chromosome condition or genetic carrier, and that a “low chance” result doesn’t guarantee a healthy pregnancy or baby.
- 3. The logistics of the testing process,** which includes information such as the sample type required (e.g. blood or saliva for carrier screening), timing of sample collection (e.g. preconception or before 12 weeks gestation for carrier screening, after 10 weeks gestation for cfDNA screening), out-of-pocket costs (some tests have full or partial Medicare rebates), and how long the results will take. For large panel carrier screening, the importance of both partners being screened at the same time should be explained.
- 4. The types of results that patients may receive, how the results will be provided, and by whom.** Patients should be aware that aneuploidy screening results provide a risk estimate, false positive and false negative results can occur, and the test doesn’t screen for every possible chromosome condition. Low chance results indicate it is unlikely the pregnancy has a significant chromosome condition, but the chance isn’t zero. High chance results are not diagnostic of a chromosome condition, and further diagnostic testing would be offered if a definitive result is desired. The chance of an increased chance cfDNA screening result being confirmed in the fetus varies according to the chromosome condition detected (positive predictive value). Patients should be made aware that they may receive a “no result”, which may be due to factors such as low fetal fraction or sample quality issues, and retesting at no cost would be an option. For carrier screening, a low chance result indicates that an individual is unlikely to be a carrier for a genetic change in the gene associated with the condition/s screened, or that a reproductive couple are unlikely to have children with any of the genetic conditions screened. However, limitations in test technology and current knowledge around genetic variants mean that not all carriers will be detected. Reproductive couples should be advised if they receive a high chance result for having children with an autosomal recessive or X-linked condition, there are reproductive options available should they wish to avoid passing the condition on.
- 5. Other less common types of results that may potentially be returned.** cfDNA screening has the potential to reveal findings that may have implications for maternal health, such as sex chromosome aneuploidy or mosaicism for a chromosome condition, or, in rare cases, an indication of malignancy. In screening tests where individual carrier status is reported, there may be health implications for some carrier results, such as an increased chance of premature ovarian insufficiency in female fragile X premutation carriers.

**6. How pregnancy management/reproductive planning may be impacted by results of reproductive genetic screening tests.** Patients should be aware that embarking on screening could ultimately result in an offer of termination of pregnancy or a change in a couple's reproductive pathway.

An understandable challenge for healthcare providers is to incorporate this pre-test counselling into their practice in a way that covers the relevant information in a timely manner while minimising information overload. It's important that healthcare providers have good resources available to provide their patients regarding reproductive genetic screening options. These may include hard-copy or online resources (e.g. fact sheets, brochures, videos, podcasts, decision aids). Some helpful resources around prenatal screening options include the YourChoice decision aid for patients for chromosome screening in pregnancy, developed by the Murdoch Children's Research Institute ([yourchoice.mcricri.edu.au](http://yourchoice.mcricri.edu.au)), and the Prenatal Screening website developed by Down Syndrome Queensland and the Queensland Health Department ([prenatalscreening.org.au/](http://prenatalscreening.org.au/)). The latter has resources for both patients and health professionals, including a RANZCOG-endorsed Practice Resource.

**Post-test genetic counselling**

Approximately 2% of reproductive couples will receive a carrier screening result indicating an increased chance for a genetic condition in their children, and a further approximately 2% of pregnant people will receive a result showing a high chance of a chromosome condition in their pregnancy. Research shows that these results are generally unexpected and come as a shock. Disclosure of the result should include some initial information about the condition for which there is an increased chance, the chance of the result being confirmed/passed on to a child, and the next steps that are available. Referral for genetic counselling can be beneficial in providing a supportive environment for people to digest the news, understand the implications of the result and make decisions about further testing/reproductive options. In some scenarios, the condition may be variable, or very rare, so it may not be possible to provide people with definitive information around prognosis, which can be particularly challenging. It is vitally important that healthcare providers are aware of referral pathways for genetic counselling for people who receive increased chance results. A list of clinical genetics services in Australia and Aotearoa/New Zealand can be found here:

[hgsa.org.au/Web/Web/HP-Resources/Clinical-genetics-services-by-state/Clinical-Genetic-Services.aspx?hkey=e11c39d6-37f4-4e68-8709-21eff5f6e006](http://hgsa.org.au/Web/Web/HP-Resources/Clinical-genetics-services-by-state/Clinical-Genetic-Services.aspx?hkey=e11c39d6-37f4-4e68-8709-21eff5f6e006)



Scan the QR Code to view the list of clinical genetic services

Emotional, psychological and practical support is paramount throughout the experience of receiving unexpected results and subsequent decision-making. Healthcare providers can also provide other resources that may be helpful for support and decision-making for people in this scenario. Through the Unexpected is an organisation providing support for parents who receive a suspected or confirmed prenatal diagnosis of congenital anomaly ([throughtheunexpected.org.au](http://throughtheunexpected.org.au)). The "One screened every minute" podcast ([onescreenedeveryminute.com](http://onescreenedeveryminute.com)) features interviews with pregnant people who have received unexpected results from cfDNA screening. Patients seeking more information about a particular condition can also be directed to the relevant patient support organisation for the condition such as Down Syndrome Australia, Fragile X Association of Australia, Cystic Fibrosis Australia, and SMA Australia.

**Summary**

Research consistently shows that people value the opportunity to understand their chance for genetic and chromosomal conditions and make informed reproductive choices. Practitioners can position themselves to effectively deliver reproductive genetic screening by ensuring they and their patients have access to information resources and support.

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# Audit of labour & birth outcomes



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In order to better understand the current challenges faced by both healthcare providers and the women in their care in Australia and Aotearoa New Zealand, a large-scale data collection and analysis audit is underway as part of a series of sessions taking place at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Annual Scientific Meeting (ASM), held in Wellington, Aotearoa New Zealand in October 2024.

In both these countries, while some hospitals and health care districts collect data on a limited number of labour and birth events and outcomes using the *Robson Ten Group Classification System (TGCS)*<sup>1</sup>, this project is aimed at using the Classification System in the collection of many more maternal and neonatal outcomes across both countries in order to analyse trends within healthcare systems by state, rurality, nation and also compare with other data collections which have been made across the world.<sup>2</sup>

Currently, Australia collects rates of caesarean sections in nulliparous women, via the *National Core Maternity Indicators*<sup>3</sup> and Aotearoa New Zealand collects rates of caesarean sections in Standard *Primiparae women via the Maternity Clinical Indicators*<sup>4</sup>, however more detail is needed to understand the trends and patterns in this sphere. It is worth noting that there is a lack of up-to-date, publicly available data via the Maternity Clinical Indicators in Aotearoa New Zealand, which along with the decision not to publish a comprehensive report on the matter since 2012, has made it more difficult to access current and accurate data regarding labour and birth outcomes. Data also has not been made available since 2018 and

relies on a web-based tool which further contributes to lack of understanding of birth outcomes in Aotearoa New Zealand.<sup>5</sup>

The lack of consistent data collation across both Australia and Aotearoa New Zealand in this important part of maternal health leaves both healthcare providers and governments as well as the women and their families at a state and federal level unable to assess the needs for improvement with healthcare systems.

Across both countries, over 25 hospitals are participating in data collection and analysis in preparation for presentation over successive sessions during the ASM: data collection from various sites across both Australia and Aotearoa New Zealand has proved challenging, with participating hospitals citing both the lack of workforce resources in being able to collect this data, along with antiquated systems of data collection and collation as barriers to providing accurate and up-to-date data for analysis.

The aim of these sessions is to aggregate information from multiple maternity care providers throughout Australia and Aotearoa New Zealand into a series of presentations of the data gathered. The intention is to showcase the data in a concise manner, followed by a panel discussion, led by Dr Michael Robson, the creator of the Classification System, who will delve into the trends and further discuss the current situation which healthcare systems find themselves, in relation to several factors relating to labour and birth outcomes. TGCS classifies women into the following groups which are totally inclusive and mutually exclusive.<sup>6</sup>

Group	Classification
One	Nulliparous single cephalic, $\geq 37$ weeks, spontaneous labour
Two	Nulliparous single cephalic, $\geq 37$ weeks, induction or caesarean section before labour
Three	Multiple single cephalic, $\geq 37$ weeks, spontaneous labour (excluding previous caesarean sections)
Four	Multiple single cephalic, $\geq 37$ weeks, induction or caesarean section before labour (excluding previous caesarean sections)
Five	Previous caesarean section single cephalic $\geq 37$ weeks
Six	All nulliparous breeches
Seven	All multiparous breeches (including previous caesarean sections)
Eight	All multiple pregnancies (including previous caesarean sections)
Nine	All abnormal lies (including previous caesarean sections)
Ten	All single cephalic $\leq 36$ weeks (including previous caesarean sections)



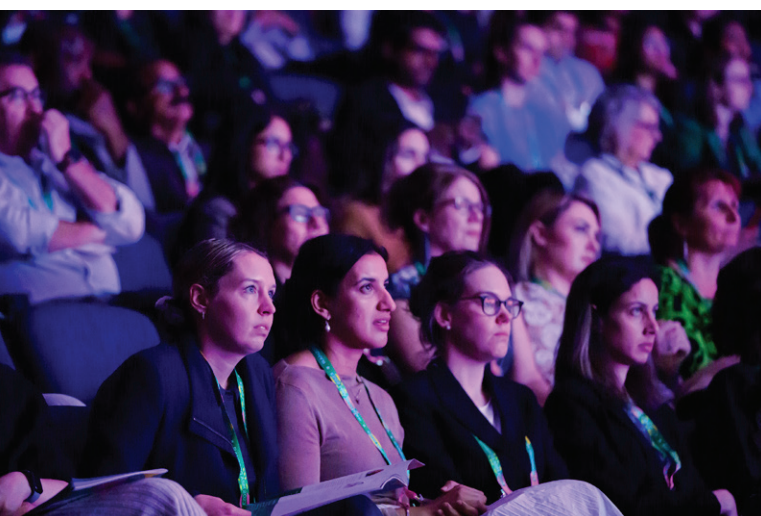
Using the TGCS, a number of other events and outcomes within the data sets are considered to uncover trends within labour, including: rate of epidurals, rate of obstetric anal sphincter (OASI) injuries, use of Oxytocin, Post Partum Haemorrhage rate ( $\leq 1000\text{ml}$ ), Spontaneous Vaginal Birth Rate, Operative Vaginal Birth Rate, Caesarean Section Rate, Caesarean Section Rate at full dilatation, Neonatal Unit Admission, Hypoxic-ischemic Encephalopathy Rate and APGAR  $<7$  at 5 minutes.

For improvement of outcomes by practitioners, and to be able to influence policy and improve maternal outcomes and implement better systems for collection and collation of data, it is integral for large-ranging studies to be undertaken by our colleagues. It is hoped that by undertaking this vitally important project, there will be momentum to further improve outcomes for the women in our care with larger scale state, region and national data collection and interpretation.

Other studies using the TGCS overseas shows that the approach to labour outcomes vary greatly based on health systems within a similar geographic region. Important insights into the rate of caesarean sections and trends within Europe between 2015-2019<sup>7</sup> are shown through an in-depth analysis using Euro-Peristat. The advantage of this study is Euro-Peristat was able to access TGCS data from twenty-seven countries within the European Union, as well as those within the geographical region outside the zone (Norway, Iceland, Switzerland and the United

Kingdom), through an established network<sup>8</sup> which provided a wide ranging and comprehensive data set for the rate of caesarean sections. The ability to contribute data was shown to be varied throughout the participating countries, as only just over half were able to provide all the data for the TGCS for review.<sup>9</sup> It further showed a decreasing rate in a third of countries in their caesarean section rate overall, however countries which were not able to contribute full data from the TGCS, tended to have the highest rates of caesarean section in the cohort.<sup>10</sup>

In countries with similar populations and healthcare systems, using the TGCS allows for benchmarking between comparable nations. Additionally, it highlights the impact on the health of mothers and babies.<sup>11</sup> Since original publication in 2001, the TGCS has been recommended by the World Health Organisation (WHO) for use worldwide to better understand birth rates and outcomes.<sup>12</sup> It is hoped that as more countries take up this data classification tool, our understanding of birth outcomes will significantly improve. Data analysed in the Euro-Peristat study in some cases was estimated, calculated and included in final report numbers in cases where the data was not available<sup>13</sup>, however for hospitals which are participating in the Australian and Aotearoa New Zealand data collection, they are encouraged to include these gaps in their data as part of their submission and presentation to further highlight the data collection issues which healthcare systems in both countries are currently facing.



Further analysis using the TGCS in various settings has provided detailed insights. For instance, a comprehensive study over 11 years at a tertiary teaching hospital in Singapore revealed a significant increase in caesarean sections. This long-term analysis highlighted the need to reduce caesarean rates by promoting vaginal births for nulliparous women and increasing the rate of vaginal births after caesarean section. The findings showed that these two cohorts were the primary contributors to the rising caesarean rates in this locality during the analysed period.<sup>14</sup>

Analysis of a Swedish maternity unit, which conducted a continuous audit from 2013-2016 of all births in their location to understand quality improvement for women and children, effectively utilised the four years of data collected to revise and improve hospital policies and guidelines, resulting in better maternal outcomes.<sup>15</sup> The authors of this study noted that the continuous use of the audit based on "clinically significant classification"<sup>16</sup> ensures the ability to improve quality. From the same cohort of patients, a study was conducted to assess their experiences of labour. The results revealed that satisfaction with labour was influenced by several factors, including duration of labour, the use of oxytocin, epidurals, and mode of birth data points also collected as part of the TGCS.<sup>17</sup>

It is hoped that contributing hospitals continue to collect and reflect on their own data and trends, and that this practise will expand to more hospitals within both Australia and Aotearoa New Zealand. This expansion will facilitate data comparisons between Australia and Aotearoa New Zealand and similar international institutions.

This data will be presented at the RANZCOG ASM from **14-16 October 2024, in Wellington, Aotearoa New Zealand.** I would like to take this opportunity to thank all hospitals involved for their hard work and contributions, as well as Dr Michael Robson, the Besins Healthcare Keynote Speaker, and Ms Sara MacArthur and Ms Kathleen McKinn from the RANZCOG Events Team who have been integral to the success of this project.

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# Obstetric care and consent: Navigating legal and ethical challenges



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There has been discussion recently about informed consent in obstetrics in light of the parliamentary inquiry into birth trauma in New South Wales and associated national media coverage. The outcome and impact of this is still developing; however, the core legal principles remain settled and should continue to guide how you communicate with and obtain consent from patients.

## Consent essentials

Obtaining patient consent through a shared decision-making process is an essential part of clinical practice. This requires clear and effective communication between doctor and patient, including discussion about the risks and benefits of proposed treatment and interventions.<sup>1</sup>

This is a well-established legal principle and reflected in professional standards such as the Medical Board of Australia's Good medical practice: a code of conduct for doctors in Australia<sup>2</sup>.

The legal duty is to provide information that any patient would reasonably need to know, and information that the individual patient would consider is material to their decision. This is a patient-centred test, and the discussion should be tailored to the patient's specific needs and concerns.

An adult with decision-making capacity has the right to refuse examinations, treatments or procedures. This applies when seeking consent from pregnant patients about treatment for her or the unborn fetus.

Avant's experience and data analysis indicate that the most common consent concerns are patients reporting that they had been given insufficient information or did not feel fully informed after the consent process.

## Obtaining consent

For many aspects of antenatal care, verbal consent is appropriate. That includes for routine physical examinations, ultrasounds, and taking samples for pathology testing. However, it is important to never assume consent, particularly for intimate examinations.

Doctors have found themselves the subject of complaints where they have assumed a patient was consenting when they did not actively object to an examination. As well as discussing the need for any test or examination, make sure the patient understands what is involved and give them an opportunity to ask questions or express any concerns.

Except in a life-threatening emergency, patients need to give consent to an intervention or procedure. This applies to caesarean section or use of instruments during delivery, and other interventions such as an episiotomy.

It does not mean that specific consent is required for vaginal delivery, since vaginal delivery is not an intervention. However, there should be discussion with patients about what to expect during the delivery, the issues or complications that may arise, and what other options for delivery may be needed.

The antenatal period provides a good opportunity for multiple discussions about these issues. As a doctor, your level of individual involvement in this process will vary across private practice and public hospital settings.

Ideally pregnant patients who are developing birth plans will be able to discuss their preferences with their healthcare team well in advance of their delivery. This can provide a good framework for discussing the material risks with the patient and reaching a shared decision about how to proceed if those risks eventuate.

Such discussions may bring to light cultural factors that may influence a patient's engagement with healthcare. It will also highlight the patient's expectations and provide time for any unrealistic expectations to be addressed.

Ultimately, the doctor who performs a procedure is responsible for satisfying themselves that the patient has provided informed consent. They do not need to personally provide all the information or have every discussion themselves. This highlights that consent is a process – the consent form is the final step in the process and evidence that the patient has agreed to proceed with the proposed treatment. This can also be documented by the treating team in the patient's records.

Many health departments and public hospitals have developed policies on antenatal and birth consent and when written consent will be required. These sometimes require written consent for certain procedures and that consent be confirmed at the time of the procedure.<sup>3</sup>

## Communication between carers

In the case of a shared-care arrangement, it is important that all members of the patient's care team are providing consistent information to the patient and have a shared understanding of what has been agreed.



Under Australian Privacy Law<sup>4</sup>, healthcare providers are permitted to share a patient's health information between members of a patient's treating team. However, do discuss this with the patient and check they understand what information will be shared and with whom, so that they have an opportunity to raise any concerns.

### Challenging decisions

Sometimes, even after thorough communication, a patient wishes to deliver their baby in a certain way or in a particular setting that goes against your clinical advice. Or they may indicate they do not want certain interventions, such as forceps during delivery. A pregnant patient is entitled to refuse treatment, even if that refusal has the potential to harm the unborn child.

This can be particularly challenging for doctors. If you believe that a birth or shared-care plan poses unacceptable risks to parent or baby, you do not have to support it.

In such cases, practitioners should explain the risks to mother and baby clearly and in a way the patient can understand. We recommend that you confirm this information in writing to the patient and the rest of treating team. You can continue to raise your concerns throughout the pregnancy, particularly as new information comes to light. Never assume that the pregnant patient has made up their mind and discussing the risks would serve no purpose.

This can be a difficult balancing act where patients have strongly held views and there is a risk they will disengage with healthcare altogether. By continuing to provide care and trying to accommodate patients' needs you will not be seen as endorsing an unsafe course. However, you must ensure that the risks are made clear to the patient and that they are accepting of those risks.

Ensure you document all your discussions, particularly where patients indicate they may proceed against your clinical advice. Document the specific risks discussed along with the possible adverse outcomes for the child and mother. This includes using the terms 'death' and 'disability' if these are reasonably foreseeable clinical risks.

If you do have grave concerns for the baby's welfare, some jurisdictions have provisions for making pre-natal child safety reports under state child protection legislation.

### Consent in urgent and unplanned situations

Ideally, the period of antenatal care will have provided an opportunity to discuss various options and interventions if things do not go to plan and decisions need to be made urgently.

If such a situation arises, shared decision-making means explaining the risks and options to the patient, give them the benefit of your expertise, and helping them reach a decision.

Doctors are permitted to act without consent where a patient is unable to consent in the case of a life-threatening emergency. However, the fact that a pregnant patient is making decisions you consider irrational does not necessarily mean they have lost capacity.

A UK court was prepared to find that a pregnant patient's needle phobia meant she had temporarily lost capacity when she withdrew consent to a planned caesarean which would have involved anaesthesia by injection. However, the court was also clear that panic, indecisiveness or

irrationality do not themselves amount to lack of capacity. These cases are rarely clear cut so always seek advice in such a situation.

### Look after yourself

We know difficult cases are deeply distressing for all healthcare staff involved. Seek advice and support from your college, or one of the support services available to healthcare professionals such as the Doctors' Health Advisory Service in your state or territory<sup>5</sup>.

Avant members can contact us for medico-legal assistance and support, including after-hours support in emergencies, at: [avant.org.au/medico-legal-notifications-and-assistance](http://avant.org.au/medico-legal-notifications-and-assistance).

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### Further reading

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# Informed consent in the birth space



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It's 2016, and the duty registrar, Kate\*, walks towards room 6. It's her third night shift, and she's been called due to a prolonged second stage. On entering, there's a midwife and her student. The room is dimly lit, but she sees the familiar look on Olivia's face: the mix of fear and relief. The midwives like Kate. She's a safe pair of hands, a quick mind, and kind with her words. She gets to work.

Fast-forward to 11th March 2023, and Olivia stands in the Preston Stanley Room at Parliament House in Sydney — the first of the New South Wales Select Committee on Birth Trauma community hearings.'

*"The midwife and obstetrician went outside the room for their discussions. The doctor told me: "We'll use a vacuum to get the baby out," without discussing the risks or asking for my consent. They tried the vacuum...then proceeded with an episiotomy and forceps without my knowledge. I had never heard of a third-degree tear until two days later."*

Over 4,000 submissions were received, and the lack, or absence of, informed consent was prominently featured in the birth stories they heard. Figure 1 outlines the five most frequently identified themes.<sup>1</sup>

## The evolution of informed consent

Medical paternalism was universal in the early 20th century. Doctors were seen as the ultimate authorities. There was no need to involve patients in treatment matters, and this was no different in the context of labour. The woman's role was to comply with all medical recommendations.

The mid-to late 20th century saw a gradual shift towards patient-centred care. Civil rights and feminist movements contributed to these developments. Several key legal cases were central to establishing informed consent as an expected standard of care. In gynaecology, pelvic mesh consent issues came to light in the mid-2010s with widespread public awareness, lawsuits, and, in Australia, the 2017 Senate Inquiry.

A review of the research literature on informed consent in labour reveals that before 2010, anaesthetic concerns about the challenges of informed consent for epidurals were the most examined topic.<sup>2</sup> By 2017, the themes moved through questions about the ability of intrapartum women to provide consent for research to the implications of the UK Montgomery ruling.<sup>3</sup>

Over the past ten years, the breadth of research concerning consent in labour has reflected the evolving public expectations and challenges of the medical profession. These centred on ethical considerations, episiotomy, induction of labour, human rights and the intrapartum implications of published guidance, such as the 2020 NSW Consent Manual.<sup>4</sup>

Today, informed consent in labour requires comprehensive antenatal education, clear communication and meticulous documentation. Challenges remain, especially when time-critical interventions are needed. The 2024 NSW Birth Trauma Inquiry findings indicate work still needs to be done.

Time pressure and communication challenges are considerations for obstetricians who must respond to rapidly evolving situations during intrapartum care. Not only is urgency required for decision-making and actions, but there's also a need to ensure the patient understands the implications of proposed interventions and can provide valid consent.

Many factors can impede communication and understanding, such as a lack of childbirth education or language and cultural barriers, which impact how information is received or interpreted. Additionally, stress, pain, and fear during labour can hinder information processing.

Figure 1. Five Most Common Issues Identified with Informed Consent  
Design: Amber Spiteri

## Practice recommendations

Childbirth education is an enabler for informed consent. Education about potential interventions must include why they might be recommended, their benefits and risks, and possible complications. Education establishes a common language, empowers women to be involved in decisions, and, where relevant, have their preferences clarified and documented in the medical record.

A more positive birth outcome will result when women are informed, empowered and able to have their preferences and autonomy respected. There is evidence that increased labour agency mitigates post-traumatic stress disorder.<sup>5,6,7</sup> Critical components of agency include autonomy, empowerment, informed consent and collaboration. Agency in labour recognises the woman as the central figure in the birth process and promotes her ability to make choices that best suit her needs and desires while being supported by her healthcare team.

A 2018 Queensland guideline<sup>8</sup> on antenatal education advocated for better information on interventions, citing a 2011 coroner's report. The coroner recommended discussing the risks and benefits of interventions in antenatal classes facilitated by midwives and obstetricians. However, the guideline relegates this education to clinic settings due to '... negative impact that the provision of negative information or risk-based discussion can have on women's experiences.'

Antenatal education in Australia is mainly led by midwives, with standards set by CAPEA (Childbirth and Parenting Educators of Australia). However, no obstetricians were consulted to prepare these standards.

Obstetricians have often delegated the responsibility of childbirth education to midwives, but this needs to change. We should be present in classes and involved in creating and distributing educational materials, such as leaflets and online videos and engaging in conversations about intrapartum interventions and follow-up question-answering. Without active involvement to ensure comprehensive and accurate information, when called unexpectedly in the second stage of labour, we perpetuate a system that fails to enable informed consent and contributes to postnatal psychological trauma.

## Information shared during consent

Obstetricians must provide up-to-date, relevant, and appropriately detailed information about interventions.

Guidance published by RANZCOG on Instrumental Birth and Informed Consent defines expectations for informed consent, as does the Medical Board Code of Conduct. In 2018, a Medical Board of Australia tribunal<sup>9</sup> heard an approach—several minutes being taken to discuss the risks and advantages of instrumental delivery vs. caesarean section. The tribunal found that the obstetrician failed to do this and, therefore, failed to obtain informed consent to instrumental delivery. It described this as conduct falling below the standard reasonably expected of a health practitioner.

# Five most common issues identified with informed consent in the NSW Birth Trauma Inquiry

## 1 Lack of Information

About procedures or options. Lack of explanation for emergency caesarean sections, insufficient information about induction policies, no explanation of interventions or possible complications.

## 2 Disregard for Choice

Women's preferences or birth plans ignored or dismissed. Decisions made without consulting women, such as non-consensual procedures, forced induction despite objections.

## 3 Communication Issues

Poor communication leading to consent issues. Miscommunication about medical conditions, insufficient explanation of procedures and risks, lack of support for non-English speakers.

## 4 Lack of Respect/Dignity

Women feeling disrespected or not treated with dignity. Instances of being treated disrespectfully during the birthing process, such as dismissive attitudes from healthcare professionals, racial discrimination, and lack of support for migrant women.

## 5 Systemic Issues

Broader problems with how consent are handled in the system, overworked staff, lack of continuity of care, and systemic failures in providing appropriate care and support.

## Forceps Delivery Script

Your baby's heartbeat is back to normal now, but I'm still concerned you might need help. This gives us some time to speak about your options from here. Can we do that when you get a breather between contractions? What have been your priorities for birth, and what are they right now?

The options depend on how far down the birth canal baby has come. If the baby were still high, caesarean might be the only way. If your baby is very low, vacuum or forceps might be the only choice. Right now, your baby is in the 'mid-pelvis', so all options are possible. Is it OK if I tell you about all three so we can decide what's right for you?

If we deliver your baby by forceps, there's a high chance of injury to your pelvic floor. This happens to at least two-thirds of women. It can include the muscle around the anus (1-in-10 or more), with a longer, more painful healing time. Incontinence of wind, stool or urine is more common after forceps. Sometimes pelvic floor tears or stretching cause prolapse or lead to it in later life. Pelvic floor injuries are less common with vacuum, but the risk is still there. An episiotomy might reduce the risk of a severe injury and is recommended, especially with forceps.

For babies, severe injury is rare but can include fractures or internal bleeding. This happens around 1-in-500 for caesarean compared to 1-in-100 for forceps, so is more common with instrumental birth. Minor cuts or bruises are common with forceps or vacuum and will heal quickly.

Sometimes, we start a vacuum or forceps but need to switch to a different method – typically from vacuum to forceps – or do a caesarean section. The risks for the baby are higher if we need to use more than one instrument.

If you have a caesarean, you're less likely to bleed heavily, but minor infections are more common, and the recovery process is different with a cut on your abdomen compared to episiotomy and pelvic floor healing. If you have a caesarean, the risks of vaginal birth in the future are higher.

That's a lot to take in, I know. Do you have any questions for me? From here, things might change if your contractions move baby further down, or if baby's heartbeat suggests low oxygen levels. I'll keep you updated on what options are available and what I recommend based on your priorities.

*Figure 2. Forceps Delivery: example script for 3-5 minutes of information sharing. Design: Amber Spiteri*

By way of example, Figure 2 outlines an information script shared before a mid-cavity forceps delivery when minimal antenatal education has taken place. It is no longer acceptable to decline to raise the option of a caesarean section or to make statements unsupported by contemporary evidence, such as forceps being safer for the mother and/or baby than a caesarean section.

In 2017, Muraca *et al.*<sup>10</sup> published an analysis of 187 234 births over ten years in Canada, finding that mid-pelvic forceps led to higher rates of pelvic floor and severe perinatal morbidity and mortality as compared with caesarean section. Rates of severe maternal morbidity were similar. Subsequent publications by the same author in 2018 and 2019 have evidenced that the risk profile varies by indication and fetal station.



Conversations during the second stage of labour are incredibly complex, and options often change during the discussion. For this reason, obstetrics skills simulation training should incorporate informed consent and trauma-informed care considerations alongside the technical aspects of instrumental birth.

Where time is even shorter, for example, persistent fetal bradycardia, a briefer approach is needed and is acceptable. Antenatal education will undoubtedly make these discussions more meaningful and less pressured. Documentation templates can ensure the breadth of these discussions is fully reflected in the medical record.

### Final remarks

Informed consent is crucial for ethical and patient-centred care. The NSW Birth Trauma Inquiry and other studies have shown the harms of inadequate consent. To address this, antenatal education and detailed, empathic communication about birth options are essential. By involving ourselves in these activities, obstetricians can foster a culture of enhanced patient autonomy and improve birth outcomes.

Kate, now a consultant, has evolved her practice. She trains her registrars in the communication skills and trauma-informed care she learned after reflecting on her own practice and changing professional expectations over the last decade. We can rise to the challenge, too.

*\* All referenced names are fictional, and details have been adjusted for anonymity.*

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# Informed fetal monitoring for labour

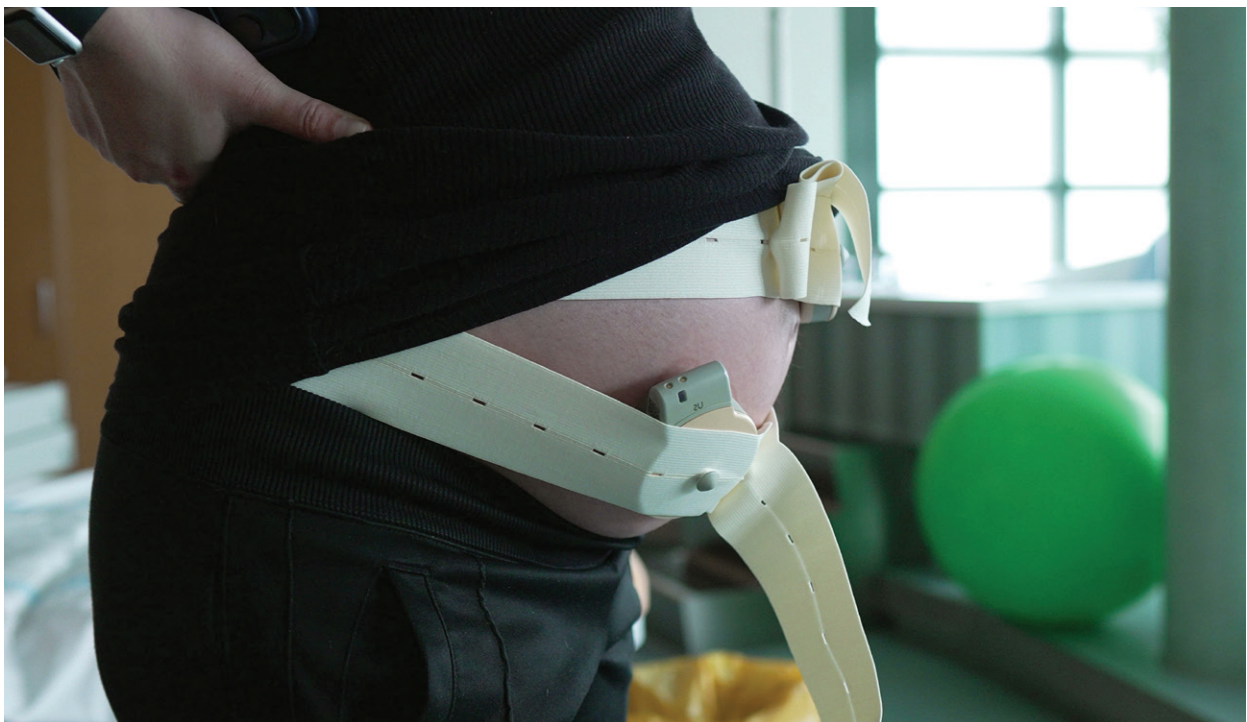


**Dr Kirsten Small**

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The choice of fetal heart rate monitoring method is a key decision for pregnant women. The selection of either IA (IA) or cardiotocography (CTG) shapes women's experiences of their birth, and potentially impacts on mode of birth and perinatal wellbeing. RANZCOG recommends women are offered information on intrapartum fetal monitoring and support for decision making.<sup>1</sup>

Most women want to participate in decisions about their maternity care<sup>2</sup>, including decisions about fetal monitoring.<sup>3</sup> Researchers have repeatedly confirmed a lack of informed consent for intrapartum CTG use in many high-income countries where CTG use is commonplace.<sup>3-11</sup> Women completing the Having a Baby in Queensland 2010 survey were asked whether they were given information and choice for a range of common intrapartum procedures<sup>9</sup>. Only 9% reported having both been given information and a choice about fetal monitoring. This continues to be an issue. Recent qualitative research on Australian women's experiences with intrapartum fetal monitoring noted a major concern was a lack of information and choice about fetal monitoring options.<sup>8</sup>



Perinatal mortality	Perinatal mortality rates were no different between women randomised to IA or to CTG use across all risk categories. Non-experimental studies confirmed these findings. <sup>14-16</sup>
Neonatal seizures	Neonatal seizures were lower among women randomised to CTGs rather than IA (15 fewer per 10,000 births). The difference applies to low- and mixed-risk populations, but not high-risk populations. In the 1985 Dublin trial, reduced seizure risk was limited to women using oxytocin. <sup>14, 17</sup>
Cerebral palsy	No research compares CTG use with IA for low-risk women for cerebral palsy. One mixed-risk trial found no difference, and one small high-risk trial (preterm labour) found a 254% increase with CTG use. Few cases of cerebral palsy are related to intrapartum hypoxia. <sup>14, 18, 19</sup>
Other perinatal outcomes	No significant differences have been found in RCTs. Some outcomes (such as breastfeeding rates) have never been examined in research. <sup>14</sup>
Mode of birth	Rates of non-instrumental vaginal birth were lower for CTG use rather than IA across all risk categories. Non-experimental research confirms higher caesarean rates when CTGs are used for low-risk women. <sup>16, 20</sup>
Other maternal outcomes	Rates of epidural use, other pharmacological analgesia, and oxytocin use were not different between IA or CTG use. Many outcomes have not been examined (e.g., perineal trauma, pelvic floor disorders, postnatal depression). <sup>14</sup>
Telemetry	No RCT has assessed telemetry. One non-randomised trial found no difference in women's satisfaction, increased mobility, lower rates of epidural use, higher rates of caesarean section, and slightly longer durations of first and second stage with telemetry. <sup>21</sup> There is little evidence to guide practice.
Fetal spiral electrodes (FSEs)	No RCT has assessed FSEs. One non-randomised study found no difference in perinatal outcomes. Women had longer labours, more vaginal examinations, and the caesarean rate was less with FSE use. <sup>22</sup> There are increased risks of fever and infection (both neonatal and maternal).
Fetal blood sampling (FBS)	One underpowered RCT compared CTG use alone with CTG use and FBS. There was a trend towards more low Apgar scores with FBS, and no other significant differences in perinatal or maternal outcomes. <sup>26</sup> There is little evidence to guide practice.
Central fetal monitoring	No RCT has assessed central fetal monitoring. Three non-randomised studies report no difference in perinatal outcomes. There is little evidence to guide practice. Central fetal monitoring impacts on women's privacy. <sup>27-30</sup>
Computer analysis of the CTG	Meta-analysis of RCTs shows no difference in maternal or perinatal outcomes. <sup>31</sup>

**Table 1.** Information that should be discussed to enable an evidence-informed decision. Design: Amber Spiteri

## Knowledge is key

Maternity professionals report the decision of whether to use IA or CTG monitoring is driven by hospital policy.<sup>11,12</sup> Mandatory hospital policies with wording indicating that some women “require” or “must have” CTG monitoring place professionals in a difficult position. Staff offering women the opportunity to make decisions about intrapartum fetal monitoring would be in breach of policy.

Other factors identified as drivers for the use of CTG monitoring include under-staffing, faith in technology, fear of liability, and social pressures.<sup>12</sup> Maternity professionals must possess accurate knowledge about fetal monitoring if they are to provide accurate information to support decision-making.

The current edition of the RANZCOG guideline<sup>1</sup> provides only two paragraphs about the evidence base for CTG use in the introductory section of the guideline, pointing out the absence of quality evidence. *RANZCOG’s Monitoring the Baby’s Heart Rate in Labour pamphlet*<sup>13</sup> describes both IA and CTG monitoring but does not include sufficient information to enable women to make an informed decision. It incorrectly asserts that fetal blood sampling may prevent the rise in caesarean sections seen with CTG use. Table 1 outlines information that should be included in conversations with all women (regardless of risk) to support their decision-making.

The recommendation to inform and involve women in decisions about fetal monitoring set out in the RANZCOG guideline is not being met consistently. Policy reform is needed to ensure women’s role as decision-maker is clear. RANZCOG could better support maternity professionals to have accurate, evidence-based discussions by updating their patient information pamphlet.

*Dr Kirsten Small is a researcher, writer, educator, and retired obstetrician/gynaecologist. Her doctoral research examined central fetal monitoring. Her blog, Birth Small Talk, and online courses provide evidence-based education about fetal heart rate monitoring and can be found at: [birthsmalltalk.com](http://birthsmalltalk.com).*

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