



Principles that Underpin Communication between Eligible Midwives and Obstetricians (GP or Specialist)

This Principles of Communication document has been approved by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian College of Midwives.

This document is intended to provide guidance for eligible midwives and obstetricians about appropriate communication in relation to the care of women who choose an eligible midwife as their maternity care coordinator.

In this paper reference to obstetrician(s) is to GP or specialist obstetricians who provide obstetric services. Reference to midwives is to eligible midwives.

Introduction

Collaboration has become increasingly important in health care. There is general agreement that increasing inter-professional collaboration improves outcomes for health care overall. Conversely, poor collaboration, referral and handover between professionals and organisations can decrease the quality and safety of care. In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. By definition, collaborating professionals trust each other, use careful and sensitive communication, and follow agreed processes for collaboration.

As regulated health practitioners, each clinician is responsible for working within and to their scope of practice, as defined by their profession, in line with their professional and organisational codes and guidelines and the relevant state or territory and Commonwealth legislation.

Eligible Midwives

Midwives wishing to provide Medicare services must have notation as an eligible midwife, in accordance with the Nursing and Midwifery Board of Australia's (NMBA) Eligible Midwife Registration Standard. A midwife's notation is reviewed every three years. To obtain notation, the NMBA requires that the midwife must be able to demonstrate, at a minimum, all of the following:

- a) current general registration as a midwife in Australia with no restrictions on practice;
- b) midwifery experience that constitutes the equivalent of three years' full-time post initial registration as a midwife;
- c) current competence to provide pregnancy, labour, birth and postnatal care to women and their infants;
- d) successful completion of an approved professional practice review program for midwives working across the continuum of midwifery care;
- e) 20 additional hours per year of continuing professional development relating to the continuum of midwifery care;
- f) formal undertaking to complete within 18 months of recognition as an eligible midwife, or the successful completion of :-
 - i. an accredited and approved program of study determined by NMBA to develop midwives' knowledge and skills in prescribing, or
 - ii. a program that is substantially equivalent to such an approved program of study, as determined by NMBA.

Under Section 225(p) of the *National Law*, where a midwife meets the requirements necessary to become an eligible midwife, the following notation is made on the register of midwives:

‘An eligible midwife competent to provide pregnancy, labour, birth and postnatal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation.’

Medicare benefits are payable for antenatal, intra-partum and postnatal services (up to six weeks post birth), when provided by midwives working in a collaborative agreement. Under these arrangements, midwives can request certain pathology and diagnostic imaging services for women in their care and refer to obstetricians and paediatricians, as the clinical need arises.

Collaborative arrangements must provide for consultation, referral and transfer of care from a midwife to an obstetrician as clinically necessary.

Interaction with a midwife's professional colleagues and with the women in his/her care, to ensure the ongoing provision of high quality, safe, appropriate care for women and babies is informed by the agreed scope of practice of a midwife as described by the WHO viz.

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

Principles of Collaboration

A commitment to shared principles of collaboration provides practitioners with a framework for individual clinical practice that can enable best-practice maternity care. These principles include:

- a shared definition and understanding of what collaboration means for maternity care e.g. a dynamic process for facilitating communication and care pathways (including consultation, referral and transfer) that enable health professionals to provide safe, high quality, woman-centred care;
- collaborating professionals trusting each other, using careful and sensitive communication, and following agreed processes for collaboration;
- that the roles and responsibilities of everyone involved in the woman's care are clearly defined, particularly for the person the woman considers to be her main carer;
- each practitioner being responsible and accountable for the care they provide;
- collaborating professionals respecting and valuing each other's roles and providing support to each other in their work;
- enabling women to be active participants in their care and to make informed decisions by ensuring that they are given information about all of their options. This information should be based on best practice and agreed to and endorsed by the professional groups; and
- maximising a woman's continuity of care throughout her maternity episode.

Communication

Communication is arguably one of the most important aspects of maternity care. Each professional is responsible for sharing accurate and appropriate information that will affect decision making. Any communication process must include the woman and her community (if she chooses).

Where a midwife is providing Medicare eligible maternity services, these services must be provided in a collaborative arrangement. It is good practice for there to be early and regular communication between collaborating health professionals about the circumstances, care and clinical condition of all women receiving maternity care, whether or not there is an expectation that a particular woman will require medical care.

Midwives who identify clinical indicator(s) that are coded “B” in the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral (2013)* should communicate with their collaborating partner/s about the condition(s) and any appropriate activity(ies).

Appropriate communication is also important in ensuring informed discussions with the woman about: when the midwife should consult, refer or transfer the care of the woman and baby to appropriate medical practitioner(s); to whom the woman or baby would be referred; and where that medical care would likely be provided.

While it is recognised that the woman is responsible for choosing her model of care, it is the responsibility of the midwife to ensure that the woman is informed and encouraged to involve other care provider(s) when indicated. The midwife must ensure that the woman is also informed, as appropriate, about the risks any failure to involve, or to delay the involvement of other care providers, pose. When relevant, these risks must be explicitly discussed, relying on accepted clinical practice and consideration of local circumstances. The discussions should be comprehensively documented.

There is a range of clinical circumstances that should trigger a midwife who is a woman’s primary maternity care giver to initiate communication with an obstetrician.

The outcome of such communication in terms of recommendations for ongoing care will vary depending on the clinical implications, local availability of different services, the discussion between the midwife and the obstetrician and the consent of the woman. Any communication may result in the simple exchange of information, advice from the obstetrician to the midwife about management, referral of the woman for a consultation with the obstetrician, or, a recommendation for transfer of the primary maternity care coordinator role to the obstetrician.

Consultation and Referral

A midwife may discuss the clinical circumstances with an appropriate health professional to select or confirm a particular course(s) of action.

The midwife may recommend that the woman herself consult with the selected health professional. Depending on the outcome of the consultation, recommendations would include that the midwife continue or not continue in his/her role as the maternity care coordinator. That is, consultation with an obstetrician does not necessarily mean that the obstetrician will become the maternity care coordinator.

The nature of the recommendation will depend on the clinical circumstances and regional issues, including resources and site and carer aspects of service provision. The obstetrician and the midwife, in consultation with the woman, may recommend:

- a) that the midwife continue as maternity care coordinator, with or without some recommendations for future management;
- b) that the midwife and obstetrician enter into a shared-care arrangement so that the woman has ongoing care provided jointly by both the midwife and obstetrician;
- c) that the obstetrician becomes the maternity care coordinator, while recognising that the midwife may continue to have an important role in even the highest risk pregnancy. It is possible that care co-ordination may be transferred back to the midwife at a later stage in pregnancy, labour or the puerperium.

Emergency management

In an emergency the clinical responsibility is transferred, as soon as possible, to the most appropriate practitioner available.

The clinical roles and responsibilities of the attending practitioners are dictated by the needs of the mother and baby and the skills and expertise of the practitioners available. In an emergency a health care provider cannot refuse to attend a woman or infant.

Relevant Materials

Aspects of these Guidelines have been drawn from a number of sources, including:

Australian College of Midwives (ACM) 2013, *National Midwifery Guidelines for Consultation and Referral*, 3rd Edition

International Confederation of Midwives (ICM) 2005, *Definition of the Midwife*, (page 1), The Hague, The Netherlands.

Ministry of Health NZ 2012, *Guidelines for Consultation with Obstetric and Related Medical Services*, Wellington, Ministry of Health. Published online 1 February 2012:
www.health.govt.nz.

National Health and Medical Research Council (NHMRC) 2010, *National Guidance on Collaborative Maternity Care*. Available online at:
www.nhmrc.gov.au/guidelines/publications/cp124

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2009, *Suitability Criteria for Models of Care and Indications for Referral Within and Between Models of Care*. Available online at:
www.ranzcog.edu.au/documents/doc_view/963-c-o bs-30-maternal suitability-for-models-of-care-and-indications-for-referral-within.html

WHO 2009, *Global Standards for initial education of professional nurses and midwives (WHO/HRH/HPN/08.6)*, page 14, World Health Organisation, Geneva. Available online at:
www.who.int/hrh/nursing_midwifery/hrh_global_standards_education.pdf