Australian Nursing and Midwifery Federation submission to the

AUSTRALIAN COLLEGE OF MIDWIVES REVIEW OF THE NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL - 4TH EDITION

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 300,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide a response to the Australian College of Midwives (ACM) public consultation for the review of the *National Midwifery Guidelines for Consultation and Referral – 4th Edition*. The objective of this review to ensure that the scope and breadth of a midwife's role and, where necessary, the clinical situations that warrant consultation and referral to other health practitioners is captured, is supported.

National guidelines are strengthened by comprehensive consultation with key stakeholders. The guidelines have been developed to establish agreed parameters for midwifery care supported by evidence and consensus. It is therefore essential that all midwives, for whom the guidelines have been developed, have the opportunity to contribute their expertise and experience to this review.

If these are to truly be national guidelines, applicable and utilised by all midwives, upon completion they must be publicly available at no cost. This is imperative for their universal uptake and utilisation.

CONSULTATION QUESTIONS

SECTION 1: Demographics

Questions 1 to 6 – Individual demographic questions related to location, type of employment and role.

SECTION 2: The three levels of consultation and referral

The three levels of consultation have remained the same however, minor changes to the description of each were deemed necessary to provide clarification and overcome uncertainty raised from prior feedback. The three levels of consultation are:

*A/A**	*Discuss*	*Discuss the situation with a midwifery colleague and/or with a relevant medical practitioner, and/or another health care provider.*
B	*Consult*	*Consult with a medical practitioner or other health care provider; and/or*
C	*Refer*	*Refer Refer a woman or her baby to a relevant medical practitioner or other health care provider.*

Section 4 of the revised guidelines explores these levels in more detail. You can access the document here. Please review this section and then provide any feedback or suggestions against the following questions.

7. To what extent do you feel the levels of consultation reflect appropriate consultation and/or referral?

Wholly Appropriate **Appropriate** Not At All Appropriate

8. To what extent do you feel the levels of consultation reflect the scope of a midwife?

- o A great deal
- **A lot**
- o A moderate amount
- o A little
- o None at all

9. To what extent do you feel the levels of consultation encourage collaboration?

- **A great deal**
- o A lot
- o A moderate amount
- o A little
- o None at all

10. To what extent do you feel the levels of consultation support a multidisciplinary approach to the provision of maternity care?

- **A great deal**
- A lot
- A moderate amount
- A little
- None at all

11. Please provide any feedback or suggestions for changes and/or wording to the levels of consultation using the space below.

The ANMF have concerns regarding the wording around caring for women who make choices outside of professional advice.

Firstly, we understand legal advice is being sought to support the position and advice outlined in Appendix A and B however as it stands, these documents do not provide strong legal protection for midwives yet give the impression they do. This is misleading. If the legal advice being sought is not able to provide clarity on the implications of midwives relying on this documentation when faced with malpractice proceedings it should be rescinded or a disclaimer added recommending independent legal advice be sought.

Secondly, the ANMF believes that consultation between health practitioners should not be restricted to instances where women have given informed consent alone (Level B). Ideally, consultations (as per Level B) should be undertaken with the woman's informed consent. However, when this is declined, midwives should be supported within the guidelines to pursue consultation. This benefits both the midwife and the woman. Midwives have a duty of care to their client to provide the best possible information to guide decision making. This is supported in the decision-making framework described in Appendix B. By pursuing consultation on behalf of the woman, the midwife is able to gain further advice to support the woman's decision-making and further understand the implications of the condition/s requiring consultation on outcomes and care. Midwives are also supported in exercising their clinical judgement with another health practitioner's viewpoint and expertise.

To reflect this, the wording on page 8, *Table 4.4 Summary of levels and associate care provider responsibilities, Level B* should be revised so that the last sentence reads "the woman will be involved in all discussions where possible".

Lastly, the draft guidelines do not reference the professional regulatory obligations as laid out by the Nursing and Midwifery Board of Australia (NMBA) required of midwives under the National Law. The *Decision-making framework for nursing and midwifery* (Available at https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx) and supporting documents have been developed to support safe professional practice. Not only can these documents provide midwives with additional decision-making support, it is mandated that midwives work within these professional frameworks for ongoing registration.

Therefore, the ANMF recommends an additional dot point be added to the 'Notes' section of 4.1 which incorporates and highlights the interplay between the draft guidelines r*ecommended levels of consultation and referral* and the *Decision-making framework for nursing and midwifery* and reinforces the importance of midwives working within regulatory boundaries.

12. Please use the space below for additional comments or feedback.

The guidelines give due consideration to the scope of a midwife whereby the midwife can exercise their clinical judgement in consultation with the multi-disciplinary team to assess risk whilst also providing clarity on specific indications for referral.

SECTION 3: Indications for consultation and referral

Indications for consultation and referral in prior versions of the National Midwifery Consultation and Referral Guidelines have been listed under four headings including:

1. *Indications at the commencement of care*
2. *Indications developed or discovered during pregnancy*
3. *Indications during labour and birth*
4. *Indications during the postnatal period*

A fifth section – Social Indications - has been proposed and added to the draft of the 4th edition.

13. Do you support the inclusion of 'Social Indications'?

- **Yes**
- o No
- o Please provide details to support your response:

The childbearing years can be a time of increased stress and vulnerability for families. Early identification, referral and access to services for potentially vulnerable women and families can optimise outcomes.

Midwives are in a unique position to assess risk, and understand and support families' social needs through the holistic and comprehensive care they provide. A relationship built on trust and empowerment, often created between midwives and women in continuity of care models, provides the ideal foundation for addressing complex social needs. Furthermore, as described in Sections 3 and 4 of the draft, where additional supports are required, midwives are well placed to coordinate and collaborate care for these families.

Therefore, the inclusion of social indicators is supported. Not only does it promote optimal outcomes for families but it also validates the complexities of midwifery care, recognises midwives role in primary health care and provides midwives with a framework to guide care for families with complex social presentations.

14. To what extent do you feel these sections reflect the totality of indications included in the Guidelines?

- o A great deal
- **A lot**
- o A moderate amount
- o A little
- o None at all

Please provide any additional feedback against these five sections (please do not provide feedback on the indications under each section at this question).

Section 3A: Indications at the commencement of care

The section 'Indications at the commencement of care' includes considerations that may warrant consultation and/or referral at the initiation of care and early in pregnancy. These include but are not limited to pre-existing medical, surgical, gynaecological, obstetric and psychological indications.

Please review this section and provide feedback or suggestions against the following questions.

15. The heading for this section is appropriate and reflects the content.

- o Strongly agree
- **Agree**
- o Neither agree nor disagree
- o Disagree
- o Strongly disagree

Please elaborate on your response and, where necessary, propose any changes to the heading:
For consistency across the document, recommend including '*clinical indications at the commencement of care'*.

16. Please outline any changes that you feel need to be made with respect to the indications outlined under this section (do not include proposed additions or removal of indications at this question).

Feedback may include suggestions to descriptions of the included indications, the associated level of consultation, language used, supporting evidence etc.

6.1.5 "Significant illicit or prescribed drug dependency".

Suggest "significant" be defined.

6.1.17 "History of COVID-19 treated" needs to be clarified. Does this pertain to history of past infection?

6.2 Please clarify "review section (evidence)" following pre-existing gynaecological disorders.

6.2.2 "Female Genital Mutilation (FGM).

In Australia, the language that is respectful and commonly used when discussing female genital mutilation with an individual and/or communities is "female cutting and /or traditional cutting" or their own preferred term. UNICEF has adopted the hybrid term female genital mutilation/cutting (FGM/C) in an attempt to bring policy and community approaches together (see reference: Homed, Intesar (2014). Female genital mutilation/ cutting: a mandatory reporting tool to support health professionals. Melbourne: Women's Health West, p 3).

Recommend changing the title of this section to "Female Genital Mutilation/Cutting" to maintain consistency with internationally adopted language.

6.2.5 "Infertility treatment".

It is becoming increasingly common for people who are not infertile to undergo intrauterine insemination/in vitro fertilisation treatments. We recommend clarifying if the level of consultation would change if a person has fertility treatments in the absence of infertility, and recommend the title of this section, "Infertility treatment" be changed to assisted reproduction or fertility treatment to be more inclusive.

The evidence provided for this section is from the United States of America (USA) that mostly discusses the risks related to multifetal pregnancies. A continuing trend in artificial reproductive technologies in Australia and New Zealand has been a reduction in the rate of multiple births (see reference: Macaldowie A, Lee E & Chambers GM 2015. Assisted reproductive technology in Australia and New Zealand 2013. Sydney: National Perinatal Epidemiology and Statistics Unit, the University of New South Wales). The recommended referral and consultation level should be determined based on risks, evidence and trends within the Australian context.

17. Are there any indications that have not been included in this section that you feel should be there? Please specify and provide rationale and any relevant evidence below.

6.1.5 Drug dependence or misuse should also include alcohol use. Safer Care Victoria reference babies born to both alcohol and opioid-dependent mothers as being at increased risk of harm and adverse outcomes and should therefore be reflected in the guidelines. (Available at https://www.bettersafercare.vic.gov.au/clinical-guidance/maternity/substance-use-during-pregnancy-care-of-the-mother-and-newborn)

Elevated BMI is a known risk factor for poor maternal, foetal and neonatal outcomes. Safer Care Victoria's *Obesity during pregnancy, birth and postpartum Clinical Guidance* recommends that a '*low risk approach to antenatal care is not appropriate'* and requires multidisciplinary input. (Available at: https://www.bettersafercare.vic.gov.au/clinical-guidance/maternity/obesity-during-pregnancy-birth-and-postpartum)

Elevated BMI is included in 6.1.1 as an anaesthetic risk but not identified elsewhere in the commencement of care indications and should be identified as a presentation requiring consultation at a minimum.

18. Are there any indications that you feel should be removed from this section?

o Yes

- **No**

19. Which do you think should be removed? Please specify, provide rationale and any associated evidence:

N/A

20. To what section, if any, is it appropriate to move these indications?

N/A

21. Do you have any other suggestions or feedback with respect to this section?

Hepatitis B and Hepatitis C are listed under *6.1.7 Gastrointestinal indications*. As a point of reference, Hepatitis B and C are more commonly acknowledged as an infectious disease. It is recommended that they be moved to section 6.1.10 Infectious diseases.

Section 3B: Indications developed or discovered during pregnancy

The section 'Indications developed or discovered during pregnancy' includes considerations that may warrant consultation and/or referral at any time during pregnancy.

Please review this section and provide feedback or suggestions against the following questions.

22. The heading for this section is appropriate and reflects the content.

- o Strongly agree
- o Agree
- o Neither agree nor disagree
- **Disagree**
- o Strongly disagree

Please elaborate on your response and, where necessary, propose any changes to the heading:

Recommended language change is 'clinical indications developed or identified during the antenatal period.'

23. Please outline any changes that you feel need to be made with respect to the indications outlined under this section (do not include proposed additions or removal of indications at this question).

Feedback may include suggestions to descriptions of the included indications, the associated level of consultation, language used, supporting evidence etc.

7.1.4 Recommend "discrepancy" with regards to SFH (symphysio-fundal height) be defined.

7.1.11 Recommend iron deficiency anaemia Hb<90 g/l be changed to <100 g/l to reflect recommendations for interventions beyond oral supplements to be considered below this threshold. (Available at: https://thewomens.r.worldssl.net/images/uploads/downloadable-records/clinical-guidelines/iron-deficiency-management-in-maternity-and-gynaecology-patients_280720.pdf)

24. Are there any indications that are not included in this section that you feel should be there? Please specify and provide rationale and any evidence below.

No

25. Are there any indications that you feel should be removed from this section?

- o Yes
- **No**

26. Which do you think should be removed? Please specify, provide rationale and evidence:

N/A

27. To what section, if any, is it appropriate to move these indications?

N/A

28. Do you have any other suggestions or feedback with respect to this section?

No

Section 3C: Indications during labour and birth

The section 'Indications during labour and birth' includes considerations that may warrant consultation and/or referral at any time during labour, birth and the early postnatal period.

Please review this section and provide feedback or suggestions against the following questions.

29. The heading for this section is appropriate and reflects the content.

- o Strongly agree
- o Agree
- o Neither agree nor disagree
- ● **Disagree**
- o Strongly disagree

Please elaborate on your response and, where necessary, propose any changes to the heading:

Recommend language change to 'Clinical indications during the intrapartum period'.

30. Please outline any changes that you feel need to be made with respect to the indications outlined under this section (do not include proposed additions or removal of indications at this question).

Feedback may include suggestions to descriptions of the included indications, the associated level of consultation, language used, supporting evidence etc.

Nil

31. Are there any indications that are not included in this section that you feel should be there? Please specify and provide rationale and any evidence below.

Nil

32. Are there any indications that you feel should be removed from this section?

- o Yes
- ● **No**

33. Which do you think should be removed? Please specify, provide rationale and evidence:

N/A

34. To what section, if any, is it appropriate to move these indications?

N/A

35. Do you have any other suggestions or feedback with respect to this section?

Nil

SECTION 3D: Indications during the postnatal period

The section 'Indications during the postnatal period' includes considerations that may warrant consultation and/or referral from one-hour post birth to six weeks postnatal. These include maternal and newborn/ neonatal considerations.

Please review this section and provide feedback or suggestions against the following questions.

36. The heading for this section is appropriate and reflects the content.

o Strongly agree

- **Agree**

o Neither agree nor disagree

o Disagree

o Strongly disagree

Please elaborate on your response and, where necessary, propose any changes to the heading.

It is noted that the heading used within the draft stipulates 'Indications during the postpartum period'. Consistency in language across the guidelines is recommended and the use of 'clinical indications during the antepartum/intrapartum/postpartum period' preferred.

37. Please outline any changes that you feel need to be made with respect to the indications outlined under this section (do not include proposed additions or removal of indications at this question).

Feedback may include suggestions to descriptions of the included indications, the associated level of consultation, language used, supporting evidence etc.

9.2.10 – *Newborn 'cyanosis or pallor'*. It is recommend that the level be changed from 'B' to 'B/C' as consultation and/ or referral may be based on the clinical presentation. Safer Care Victoria recommend further investigation and management of a newborn with cyanosis to exclude significant disease or illness. (Available at: https://www.bettersafercare.vic.gov.au/clinical-guidance/neonatal/cyanosed-neonate-assessment)

38. Are there any indications that are not included in this section that you feel should be there? Please specify and provide rationale and any evidence below.

Section 9.1.4 '*Suspected/ actual postnatal depression'.* It is recommended that this indication also include 'and/or anxiety'. NHMRC COPE guidelines term Anxiety disorder as being representative of several other psychological disorders including; generalised anxiety disorder, obsessive compulsive disorder, panic disorder, social phobia, specific phobia and post-traumatic stress disorder. It is also equally prevalent and strongly linked with depression occurring in the perinatal period. (Available at: https://www.cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf)

39. Are there any indications that you feel should be removed from this section?

o Yes

- **No**

40. Which do you think should be removed? Please specify, provide rationale and evidence:

Nil

41. To what section, if any, is it appropriate to move these indications?

N/A

42. Do you have any other suggestions or feedback with respect to this section?

Nil

SECTION 3E: Social indications

The section 'Social indications' was proposed following review and update of the existing sections. It includes social considerations that impact the woman and/or family during any stage of pregnancy, birth and the postnatal period.

43. To what extent do you agree that this section is needed?

- **Strongly agree**

o Agree
o Neither agree nor disagree
o Disagree
o Strongly disagree

44. The heading for this section is appropriate and reflects the content.

o Strongly agree

- **Agree**

o Neither agree nor disagree
o Disagree
o Strongly disagree

Please elaborate on your response and, where necessary, propose any changes to the heading.

Nil

45. Please outline any changes that you feel need to be made with respect to the indications outlined under this section (do not include proposed additions or removal of indications at this question).

Feedback may include suggestions to descriptions of the included indications, the associated level of consultation, language used, supporting evidence etc.

Nil

46. Are there any indications that are not included in this section that you feel should be there? Please specify and provide rationale and any evidence below.

To ensure that the list of social indications is comprehensive, it is recommended that an additional section be added to Section 10. This may include '*other identified vulnerabilities'*, representing any other social indicator that may be encountered when working alongside families with complex social needs. This will broaden midwives clinical judgement and allow for timely referral to optimise outcomes.

47. Are there any indications that you feel should be removed from this section?

o Yes

- **No**

48. Which do you think should be removed? Please specify, provide rationale and evidence:

Nil

49. To what section, if any, is it appropriate to move these indications?

N/A

50. Do you have any other suggestions or feedback with respect to this section?

Nil

SECTION 4: Additional feedback or suggestions

51. Please use the space below to provide any additional suggestions or feedback not provided in earlier sections.

Development

National guidelines can only be nationally applicable if they have been developed through a comprehensive and systematic process involving broad and in-depth consultation with key stakeholders. Key stakeholders not only include professional groups but also the individual midwives the guidelines have been designed to support.

The ANMF believes further effort should be made to broadly consult on the draft guidelines beyond the selected professional organisations and ACM members.

It is also disappointing the draft guidelines have been released in an incomplete form for stakeholder and public consultation. The appendices form a significant component of the document and an introduction provides the underpinning intent and philosophy. These are both absent from the public consultation and will impact on the final document. For example, the legal advice being sought for the appendices underpins the levels of consultation and the associated guidance to midwives. Further broad public consultation on the draft in full should be prioritised over expediting completion of the review.

Access

The ANMF has significant concerns with the current availability of the Consultation and Referral Guidelines.

It is our understanding that the guidelines are intended to be widely utilised in midwifery practice, regardless of the context of practice, to bolster evidence-based midwifery care and referral pathways. This cannot occur unless they are easily accessible and freely available to all midwives. To guard the guidelines behind an ACM paywall excludes the majority of midwives from accessing them and greatly diminishes their contribution to the advancement of the midwifery profession.

Furthermore, the guidelines are referred to in national regulatory standards and frameworks for midwives and are therefore a component of midwives' regulatory obligations. Again, to only provide the guidelines at a cost, does not support the midwifery profession.

This limited access also impacts the broader community, which does not serve midwives striving for excellence in maternity care. Giving other health practitioners beyond midwives, such as General Practitioners, Obstetricians, Paediatricians, and allied health practitioners access to the guidelines will support collaboration, consultation and referral, evidence sharing, and defend midwifery care.

The guidelines should also be available to women and their families. Decision-making in midwifery practice occurs in partnership with women and their families. Therefore, women and their families should be able to access the frameworks and evidence, which guides their care, if they wish to do so.

If these are to be national guidelines, applicable and utilised by all midwives, they must be publicly available at no cost, not only to midwives but any health practitioner providing, or woman receiving, maternity care. This is imperative for their uptake and utilisation to ensure consistency across practice, and to support clarity and open communication between health practitioners, women and their families.

Evidence

There are inconsistencies throughout sections 6 to 10 with the information in the "summary of evidence/ consensus" column. For some new additions there are no comments or just general statements, such as 'reflects increasing incidence', indicating why the disease/condition has been added. For items where the level of recommended consultation has not changed it just states 'no change'. None of these comments provide evidence to support their addition or original inclusion and recommended level of consultation.

Whilst acknowledging evidence is not available to inform all recommendations, the ANMF suggest where there is evidence available, even when this has not changed since previous editions, that this be included in the summary of evidence.

We also seek to clarify if the summary of evidence will be included in the final document. It is important midwives and other health practitioners involved in the provision of maternity care are able to reflect on, and understand the evidence underpinning their practice. This also allows for the weight of any new evidence that becomes available prior to the guidelines next review to be assessed and compared with that which has been determined relevant to guide practice at this point in time.

Utilisation

The accompanying documentation provided alongside the stakeholder and public consultation states that '*As the Guidelines are not policy they should not be used as a substitute for an individual midwife's decision-making and judgment.*' The ANMF has significant concerns with this statement. In many instances, midwives' conduct is judged by their adherence to the guidelines and the guidelines are utilised as policy by many organisations. For example, the New South Wales government has a policy directive to '*ensure that all midwives providing midwifery care utilise the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral.*' (See reference: Policy directive: maternity – National Midwifery Guidelines for Consultation and Referral, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_008.pdf).

Whilst the ANMF acknowledge ACM have no control over how the document may be utilised by individuals, health organisations or governments, it does not benefit midwives for ACM to not recognise how the guidelines are currently being utilised and the subsequent impact on midwifery practice and review. The introductory sections, missing from the draft document, must provide further information about the intent and scope of the guidelines and address the current inclusion of the guidelines in policy directing midwifery care.

Furthermore, it is important that the ACM have a strategic implementation plan to ensure all midwives and other professions involved in maternity care know that the revised guidelines are available and how to access them. As previously discussed, the guidelines not only need to be freely available to all midwives but widely and publicly available, to truly be national guidelines.