

Obstetricians and midwives *modus vivendi* for current times

Obstetric services need to be women-centred and based on mutual respect and collaboration

Obstetricians and midwives have complementary roles in the care of pregnant women, and each group would find survival without the other difficult. Nor would women necessarily receive the best care if access to one or other of these professions were restricted. Having complementary roles, though, has not prevented hostility or “turf” wars between the two groups, with midwives claiming that maternity services are over-medicalised,¹ and obstetricians counter-claiming that there is no demand for midwife-led care.² So what is the current *modus vivendi* for obstetricians and midwives, and to where feasibly could it evolve by 2020?

Maternity services in Australia in 2005 provide much choice for women, including private or public care by obstetricians, general practitioners and midwives. These services can take place in traditional hospital obstetric units, birthing centres and, now less frequently, at home. Australia has not followed the New Zealand model of care in allowing women to choose a midwife as a “lead maternity carer” as a mainstream option in the public health system. However, in some Australian states, this may soon change.³ If this were to eventuate, Australia would do well to look at the lessons learned from the experience in New Zealand.

Across the Tasman many positive changes have resulted from maternity services reform, such as significant improvement for many women in continuity of maternity caregiver, and greater availability of non-medically based models of care for those women wanting them. But negative changes have also occurred, such as the effective loss of the option for women to have a GP involved in their maternity care, and an initial exodus of experienced midwives out of the public hospital system. In particular, the sheer pain of major change, for both women and care providers, could have been minimised by thorough and consultative planning.

Given all this choice, why should there be hostility between obstetricians and midwives? The main criticisms from midwives stem from a perception that obstetric care in Australia is too medicalised and that obstetric intervention rates are too high.⁴ Because better continuity of care from a known midwife may lead to fewer obstetric interventions⁵ and greater certainty for women, there has been a strong push by midwives and consumer groups, such as the Maternity Coalition, for funded midwife-led care.⁶ On the other hand, obstetricians point to an established system of care, with low rates of maternal and perinatal morbidity as well as generally high levels of community satisfaction.²

Provision of maternity services in Australia has also been made more difficult by workforce issues. The average age of obstetricians in Australia is 51 years⁷ and of midwives 41 years.⁸ The workforce survey carried out by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in 2003 revealed that a quarter of Australian Fellows were now aged 60 or more.⁷ The same workforce

survey also highlighted the possibility of a major shortage of obstetricians in the next 10 years, due to retirements, new RANZCOG Fellows not wishing to practise obstetrics, increased feminisation of the obstetric workforce, and problems associated with safe working hours.⁷ There has also been a major decrease in GPs practising obstetrics, especially in rural areas, for lifestyle reasons and because of the cost of medical indemnity.⁹

The shortage of midwives is also a problem. The Australian Health Workforce Advisory Committee estimates a current national shortage of 1850 midwives, and this is expected to increase over the remainder of the decade.⁸ Problems with recruiting and retaining midwives seem to be related to midwives’ perceptions of a lack of professional recognition, stress and workload issues, as well as limited opportunities for

midwives to practise as primary carers and provide continuity of care to women.¹⁰

To facilitate discussion between maternity care providers, the RANZCOG re-established the Joint Committee for Maternity Services in

2002. This has representatives from the RANZCOG, the Australian College of Midwives, the Royal Australian College of General Practitioners, and the Australian College of Remote and Rural Medicine, as well as consumer representation. Each representative feeds back to his or her governing body, with the committee proving useful in airing problems and encouraging a collaborative approach to maternity care provision. The committee has made some progress in reviewing international clinical guidelines for possible use in Australia, but has been hampered by lack of funding, obstetricians suspicious of change, and midwives frustrated by lack of change. Difficulties have arisen in reconciling differences between obstetricians, GPs and midwives in how to provide safe evidence-based care that will not diminish current levels of safety.

By 2020, it can only be hoped that an Australian National Maternity Policy will be in place. At present, there is none. If this is to occur, obstetricians, GPs and midwives must work to develop collaborative policies that are women-centred, not provider-centred, and which will ensure individualised care to meet the particular needs of each pregnant woman. The development of adequate continuing professional development programs (CPD) for all maternity care providers should be mandatory, and the development of some joint CPD programs crossing profession groups would be useful. There should be development of systems of care that allow for continuity of care for women during pregnancy, labour and postnatally, but which protect against burnout of care providers.

There are already good examples of effective services in various places across Australia, ranging from large metropolitan units, such as the Adelaide Women’s and Children’s Hospital Community Midwifery Program, to rural services, such as those provided at Wangaratta Hospital in Victoria, that are women-centred and based on mutual respect and collabo-

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ration between obstetricians and midwives. The challenge is to make this the norm for the benefit of mothers and babies as well as their care providers.

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