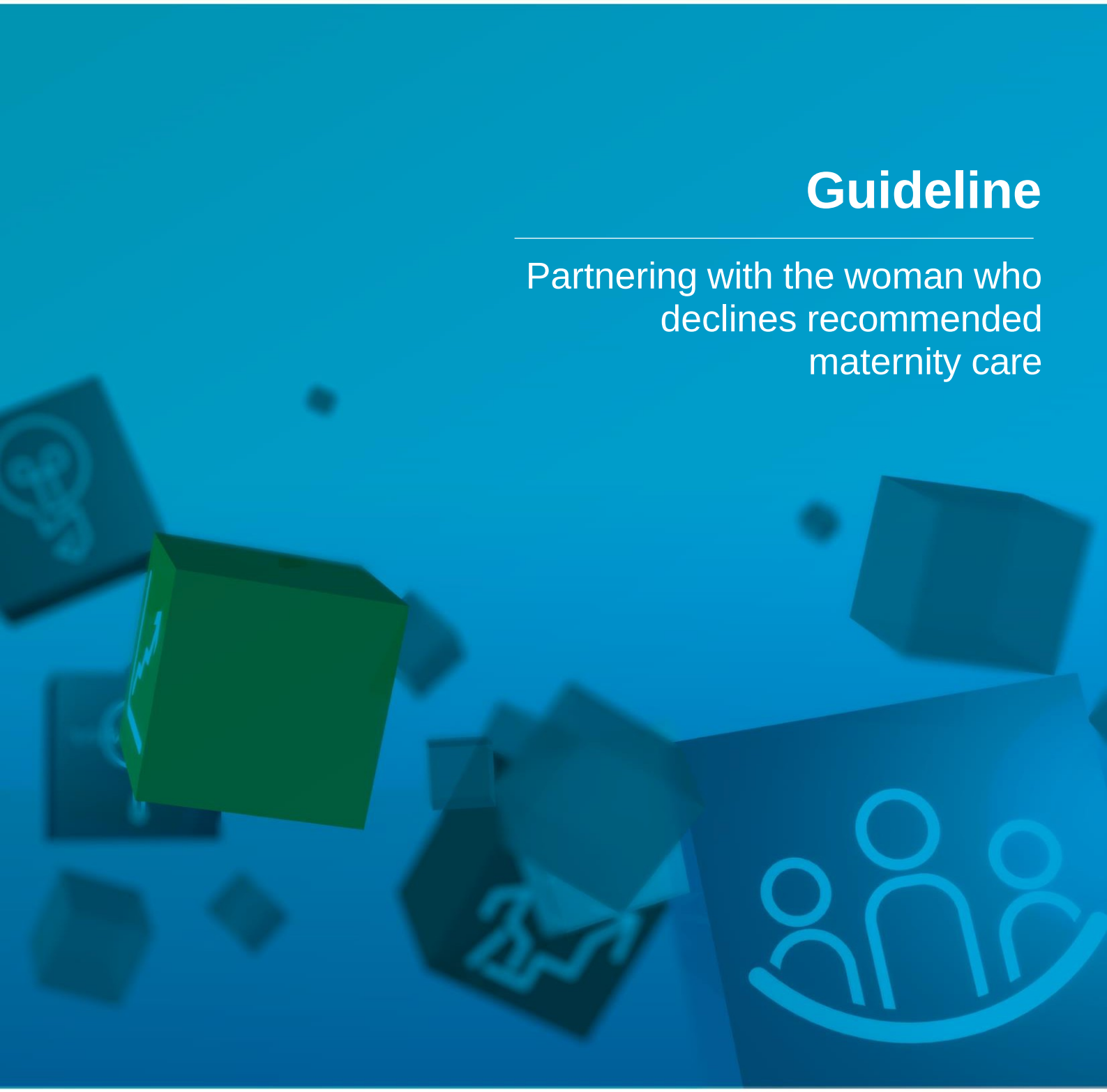
Queensland Health

Clinical **Excellence** Queensland

Guideline

Partnering with the woman who declines recommended maternity care



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Cultural acknowledgement

We acknowledge the Traditional Custodians of the land on which we work and pay our respect to the Aboriginal and Torres Strait Islander Elders past, present and emerging.

Guideline: Partnering with the woman who declines recommended maternity care

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For more information contact:
Patient Safety and Quality, Clinical Excellence Queensland, Department of Health, GPO Box 48, Brisbane QLD 4001, email PSQ_Comms@health.qld.gov.au, phone 07 33289430.

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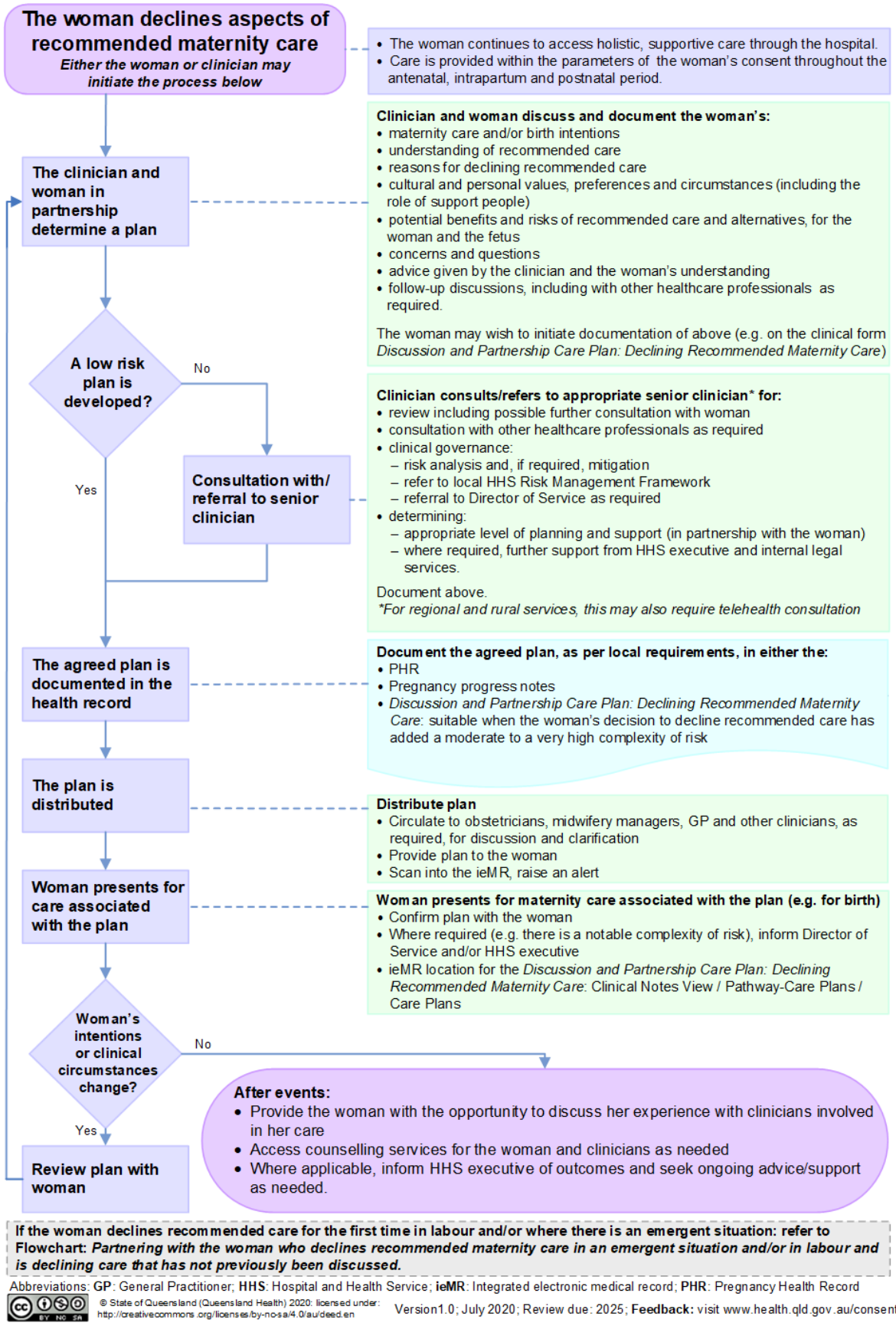
Flow chart: Partnering with the woman who declines recommended maternity care



Abbreviations: **GP**: General Practitioner; **HHS**: Hospital and Health Service; **ieMR**: Integrated electronic medical record; **PHR**: Pregnancy Health Record

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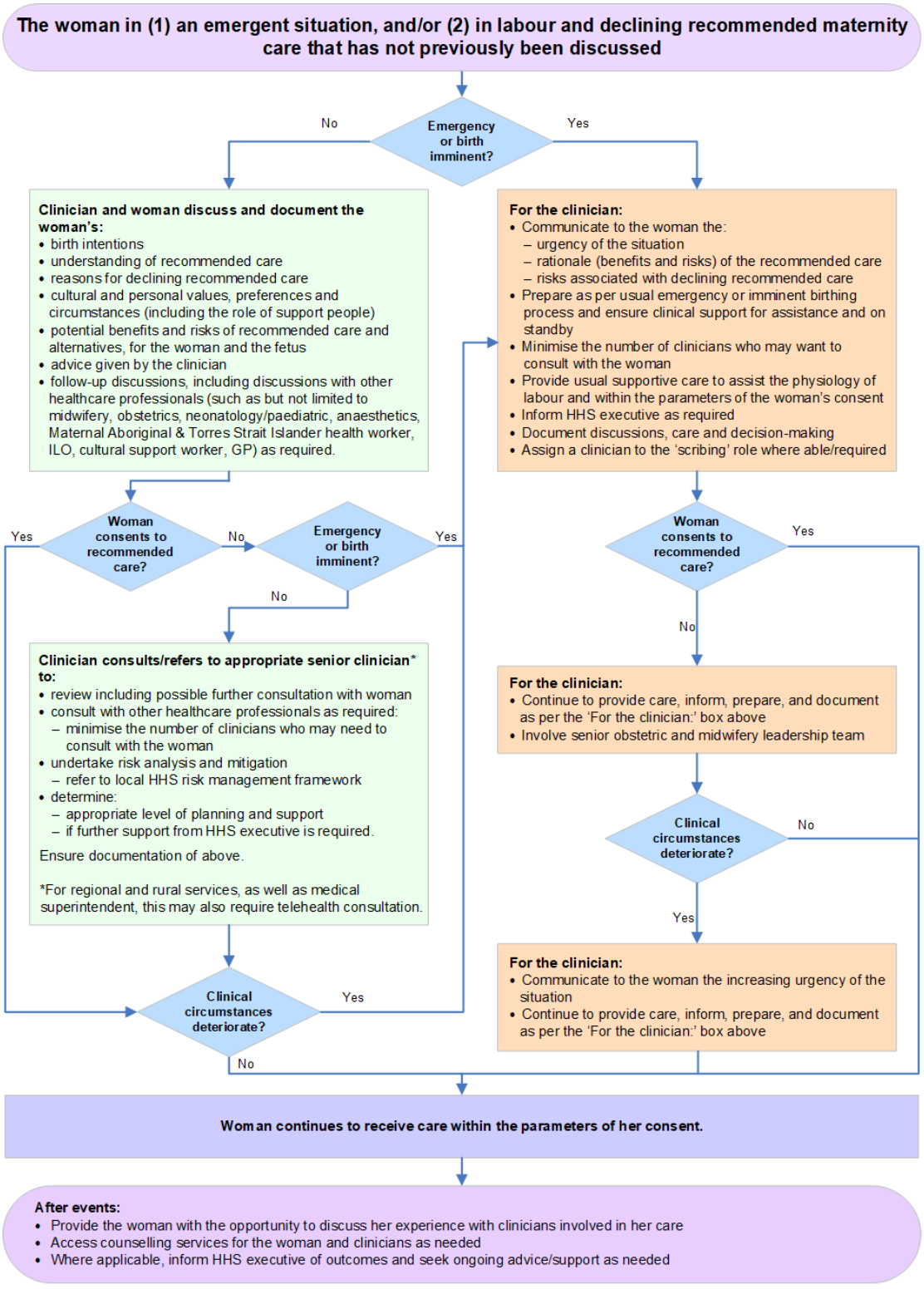
Flow chart: Partnering with the woman who declines recommended maternity care in an emergent situation and/or in labour and is declining care that has not previously been discussed



Abbreviations: GP: General Practitioner; HHS: Hospital and Health Service; ILO: Indigenous Liaison Officer

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Key messages

Principles and actions for clinicians/health services
1. Women have the right to decline recommended maternity care.(1-3)
1.1. Encourage the woman to make fully informed decisions by discussing available care and treatment options, including expected outcomes, risks and benefits.(4) 1.1.1. Identify, where applicable, benefits and risks, including any limitations, of the woman's preferred birth setting.(5) 1.1.2. Provide women with information and support that is evidence-based, culturally appropriate and tailored to their needs.(5) 1.2. Inform the woman of their right to decline treatment or withdraw consent at any time.(6) 1.2.1. Provide information to the woman on the right to decline recommended maternity care (e.g. consumer information, how to access this guideline). 1.3. Avoid all forms of coercion during the informed decision-making process. 1.4. If the woman declines recommended maternity care: 1.4.1. Ensure the woman continues to feel safe and supported. 1.4.2. Discuss alternate care options.
2. Women must not be denied access to maternity care because of their decision to decline recommended care.(3)
2.1 When the woman declines recommended maternity care, continue to: 2.1.1 Provide holistic, culturally supportive care and informed choice for the woman 2.1.2 Risk assess evolving clinical situations, clearly informing the woman about how changing circumstances, and where applicable the planned place of birth, may impact her or her baby's health. 2.2 Respect the woman's decision regarding place of birth, including declining transfer to another facility. 2.3 The woman's decision to decline recommended maternity care informs the clinician's clinical decision-making. 2.4 The healthcare service will support the clinician's clinical decision-making with regard to the woman's decision to decline recommended maternity care.
3. Good communication with women and between clinicians, the health care facility, and the Hospital and Health Service executive underpins high quality care in situations where women decline recommended care.
3.1 Provide information to the woman on the process of declining recommended maternity care, including how to access this guideline. 3.2 Contemporaneously document discussions and outcomes of the discussions. 3.3 Inform the woman of the role of the patient liaison officer. 3.4 Follow the local health care facility's clinical communication process, or implement a process, to effectively communicate, including documenting, alerting and distributing, to the necessary clinical staff and the woman, the care plan which is developed after a woman declines recommended maternity care.

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1 Introduction

The pregnant woman, the same as any other legally competent adult, has the right to decline recommended healthcare. The woman and her maternity care providers may have the shared goal of healthy woman and healthy baby; however, they may disagree about the best way to achieve this.

Queensland Health aims to provide the best possible maternity services. Rates for severe adverse pregnancy and birth outcomes are relatively low in Australia.(7) However, the woman may not view safety in relation to only physical outcomes. The distinctive importance of the childbearing period is internationally recognised(8):

> In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. The concept of 'safe motherhood' is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including choice of companionship wherever possible.

Essential to this, is ensuring the woman is placed at the centre of her own care and including the other established principles of collaborative maternity care such as, but not limited to(9):

- respect, safety, choice and access
- clinicians providing the best evidence to aid the woman's informed decision-making
- informed consent.

In Queensland, the principles in the *Human Rights Act 2019* (Qld)(10) must be taken into account by Queensland Health, Hospital and Health Services and other public entities. These principles may incorporate considerations around a woman's right to decline recommended health care or advice, if they choose, or to withdraw consent at any time.

Please note that whilst 'baby' may be used in communication with the woman, this guideline uses the term 'fetus', not 'baby', to highlight the differing legal status of a born and unborn baby.

1.1 Purpose

The purpose of this guideline is to support a partnership between a woman and her maternity care providers when the woman declines, or expresses an intention to decline, aspects of recommended maternity care. It is intended to support safe and high quality maternity care through:

- strategies for communicating with the woman, including:
  - eliciting her perspective and understandings
  - providing evidence-based advice on care choices, along with their benefits and risks
- supporting clinicians to continue to provide holistic, supportive care to the woman
- assisting with the ongoing informed decision-making process after the woman declines recommended care
- understanding of the respective roles, responsibilities and accountabilities of the woman, clinicians, and the health service
- communication, including clinical handover, and consultation between clinicians, regarding the woman's ongoing maternity care, as well as with Hospital and Health Service (HHS) executive and legal services
- developing a plan with the woman for her ongoing maternity care
- documentation standards.

1.2 Scope

This guideline is intended for use in Queensland public hospitals providing maternity care in the following situations:

- A woman declines one or more aspects of recommended care at any point in her pregnancy, birth or postnatal period.
- A woman recognises that her intended (desired) care may be different from routine or recommended practice and wishes to secure support for an alternative approach.
- A clinician is concerned that a woman's decision or intention to decline recommended care may limit their capacity to provide safe clinical care and may potentially contribute to poor outcomes for the woman and/or her fetus.
- A clinician is concerned that a woman's decision or intention to decline recommended care may require them to provide care that is outside their scope of practice or outside the clinical services capability of the health service.

This guideline does not include or cover the following situations:

- The woman requesting intervention that is not clinically indicated.
- The informed decision-making process which may precede the woman declining aspects of recommended maternity care.
- Where the woman lacks capacity to make decisions about her healthcare.
  - It should not be assumed that the woman lacks capacity to make a decision solely because she declines recommended care.(11)
- Where, following birth, a parent declines care recommended for their baby.

For further information, refer to the Queensland Health *Guide to informed decision-making in health care.*(11)

1.3 Recommended care definition

Recommended care in the context of this guideline is care that is clinically recommended.
Recommended care:

- should be informed by:
  - evidence or, where evidence of sufficient quality and/or applicability is not available, an expert working group consensus opinion (e.g. best practice clinical guidelines)
  - recognising the quality and/or applicability of the underlying evidence affects the strength of the recommendations
- is intended to provide the best outcomes for the woman and her fetus, that is, when compared to other options it is generally expected to have greater benefits and/or lower risks for the woman and her fetus
- will have associated benefits and risks
- is bound by the uncertainty of predictive care outcomes and the limitations of medical knowledge(12)
- can be personalised in light of the woman's cultural and personal values, preferences and circumstances.

1.4 Declining recommended care

Declining recommended care, in the context of this guideline, refers to a range of situations where the woman does not consent to recommended care. Every woman has the right to decline care. This may include care that is:

- routine
- discussed as part of the informed decision-making process(13)
- recommended in the antenatal, intrapartum or postnatal period
- recommended for the benefit of herself and/or her fetus
- specified in local service policy documents and/or best practice clinical guidelines
- previously consented to (that is, the woman may change her mind and withdraw consent)
- against her cultural needs or religious/spiritual beliefs (refer to Section 2.1 Cultural safety).

On many occasions when a woman declines recommended care, an agreed way forward can be identified.(14) When it is not possible to reach an agreement, the woman must continue to receive respectful, supportive maternity care that is within the parameters of her consent.

1.5 Clinical standards

Implicit throughout this guideline are the principles of:

- woman-centred maternity care, including as per the World Health Organization(15) recognised Universal Rights of Childbearing Women(8) and the Australian Charter of Healthcare Rights(3), which establish the woman's rights to:
  - access healthcare
  - receive safe and high quality care
  - respect, dignity and consideration, including for choices and preferences
  - be informed about services, treatment, options and costs in a clear and open way
  - be involved in decisions and choices about care to the extent that the woman wishes
  - refuse or withdraw consent at any time
  - equality, freedom from discrimination, and equitable care
  - liberty, autonomy, self-determination and freedom from coercion
- informed decision-making and consent as fundamental components of care
- professional scope of practice
- professional codes of conduct:
  - Good Medical Practice: a code of conduct for doctors in Australia(16)
  - Code of Conduct for Midwives(17)
- collaborative maternity care(9)
- care is provided in accordance with the:
  - Clinical Service Capability Framework, Queensland Health(18)
  - Local HHS Risk Management Framework
  - National Safety and Quality Health Service Standards (NSQHSS), Australian Commission on Safety and Quality in Health Care (ACSQHC).(19)

2 Cultural considerations

2.1 Cultural safety

When caring for the woman, in particular, the Aboriginal and Torres Strait Islander woman, and the woman identifying as culturally and linguistically diverse(20, 21):

- consider risk and safety in the social, emotional, cultural and financial context, as well as the bio-medical context
  - the woman may want the support of a cultural support person/worker
- recognise that being separated from land, language, culture and families, especially older children, during birth may signify an intolerable threat to the woman's and her family's safety.

Where the woman declines recommended care, discuss other ways healthcare may be provided, including when transfer is declined. The woman's choice on where to give birth, including birthing on country, should be respected.(21) For further information, refer to:

- Section 4.3 Hospital and health service roles and responsibilities
- The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women(21)
- Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025(22)
- Appendix A: Resources supporting culturally capable healthcare.

2.2 Interpreters

For the woman who has difficulty communicating in English, including written or the use of professional health language:

- use an accredited or recognised interpreter for the informed decision-making process
  - clinicians have a requirement to understand and ensure the woman has understood the informed decision-making discussions
  - the clinician should be able to justify any decision not to use an accredited interpreter, with reasons including the circumstances well documented
- friends and family members, including children and young relatives should not be used as interpreters
- refer to the:
  - Queensland Language Services Policy(23)
  - Language Services Guidelines(24)
  - Local facility policy and guidelines.

3 Ethical and legal considerations

3.1 Ethical context

In Queensland, ethical principles are supported by the underlying principles of the Human Rights Act(10) where respect, protection and promotion of human rights is central. Four commonly held broad ethical principles, autonomy, beneficence, non-maleficence, and justice form a framework within which healthcare decision-making can occur.(25) Of these four principles, autonomy is prioritised in contemporary bioethics.(26) Refer to Table 1 Four ethical principles.

Table 1 Four ethical principles

Principle	Consideration
Autonomy	• The right to make one's own decisions and life choices.(25) • Regarding the fetus as a patient with separate rights to the pregnant woman undermines the woman's autonomy.(27, 28) • A woman has the right to decline recommended care, even if doing so is likely to lead to a poor outcome for the woman or fetus.(27) – This right does not extend to receiving requested care (e.g. caesarean section (CS), induction of labour), if the requested care is not consistent with good clinical practice. • Concerns about respect for their autonomy have led some women to disengage from maternity care and, despite identified obstetric risk factors, give birth at home including freebirthing (homebirth without skilled attendant).(29, 30) • Good clinical practice involves respecting consent and refusal. In situations where the clinicians feel challenged(31), refer to: – professional codes of conduct(16, 17) – HHS support – Section 10 Supporting clinicians
Beneficence	• A moral(25), legal and ethical obligation to act for the benefit of others, helping them to further their important and legitimate interests, at times preventing possible harm. • Clinicians may have ethical and medico-legal concerns(31-36) when partnering with a woman who declines recommended care, including concerns that a woman's decision or intention to decline recommended care may: – limit their capacity to provide safe care, and contribute to poor outcomes for the woman and/or her fetus – require them to provide care that is outside their scope of practice or outside the clinical services capability of the health service.
Non-maleficence	• Requires that harm not be inflicted intentionally, and is closely linked to the imperative to minimise harm,(25) including physical or psychological harms.
Justice	• Prescribes actions that are fair to those involved.(25) • Suggests that like cases should be treated alike and that variations in management must be justified by relevant clinical and/or evaluative conditions.(25)

3.2 Valid consent

For the woman's informed consent to healthcare to be valid, certain conditions must be fulfilled(11):

- The woman has the capacity (ability) to make a decision about the specific issue at the specific time, and is not affected by therapeutic or other drugs, including alcohol, or other forms of cognitive impairment
  - Clinicians work on the presumption that every adult woman has the capacity to decide whether to agree to or decline healthcare (including an examination, investigation or any form of treatment) except when it can be shown by a clinical assessment they do not have the capacity to make such a decision.
- The consent is voluntarily given, and free from manipulation by, or undue influence from, a partner, family, clinicians or other social coercive influences.
  - Whilst a clinician should address a woman's biases and misconceptions(37), clinical, ethical, and medico-legal concerns(31-36) have led some clinicians to pressure women to comply with recommended care(38, 39) which may include inappropriately suggesting or involving external agencies (e.g. child protection, where there are not reasonable grounds to suspect the fetus may be at risk of harm following birth). The use of coercion to convince the woman to accept recommended care invalidates consent.(11)
- The discussion between the woman and the clinician is transparent, well balanced, and involves two-way communication which is sensitive to the situation.
- The woman can clearly understand the information because it is provided in a language or by other means the woman can understand [refer to Section 2.2 Interpreters].
- As far as possible, the woman is advised in terms that she understands of:
  - the diagnosis
  - the recommended healthcare, including the expected benefits, common side effects and alternative healthcare options
  - the material risks including complications associated with:
    - the recommended healthcare
    - alternative healthcare options
    - declining to receive the healthcare offered
  - any significant long term physical, emotional, mental, social, sexual or other expected outcomes
  - the anticipated recovery implications.
- The woman has sufficient time to consider and consult with family or other clinicians and to clarify information in order to make an informed decision, taking into account the context of the clinical situation.
- The information provided and the consent given relate to the specific healthcare provided.

Further consultation may be required to adequately cover the conditions of valid consent.

Refer to the *Guide to informed decision-making in health care*(11) for clinical situations where it is difficult to obtain valid consent, including:

- emergency care
- where the woman may be impacted by factors such as pain and medications during the birth process and temporarily lacks capacity to make decisions and give informed consent
  - avoid seeking consent during a contraction.

3.2.1 Valid consent documentation

The woman's written consent is advisable and recommended for any health care which carries significant risk and/or where the healthcare is controversial. However, a signature on a consent form or partnership/care plan is not considered to be enough to show that consent is valid and informed. Likewise, no signature does not mean that valid consent has not been obtained. In all circumstances, the clinician should ensure comprehensive documentation, with appropriately specific and detailed information of the discussions held and the communication process followed to develop the woman's care/partnership plan(11) (refer to Sections 5 Initial discussions, 6 Follow up discussions, Appendix B: Discussion and partnership care plan).

3.3 The woman's right to decline recommended care

Any patient who has capacity to consent may also decline any or all healthcare at any time, even when this is contrary to medical recommendations and in circumstances where such a decision to decline healthcare may result in death.(11)

3.3.1 Declining care recommended for fetal benefit

Australian courts have consistently upheld the right to refuse medical treatment (see *Hunter and New England Area Health Service v A* [2009] NSWSC 761 and *Brightwater Care Group v Rossiter* [2009] WASC 229)(41, 42).

The situation of a pregnant woman declining treatment recommended for fetal benefit has rarely been considered by the courts.

If an Australian court were required to consider an application for authorization of a medical procedure to be performed on a pregnant woman declining treatment, it is likely the court would follow the position taken by English courts(43, 44), where the matter was largely settled by *Re MB* [1997] EWCA Civ 3093. Australian superior court judgements, including *Hunter and New England Area Health Service v A* and others, have approved the legal test for capacity outlined in Re MB, which established that a competent woman with capacity has the right to refuse medical intervention, even if the 'consequence may be the death or serious handicap of the child' [paragraph 30].

In Re MB, the court found that a fetus does not have separate legal interests that can be taken into account before birth. This position was further affirmed in *St George's Health Care NHS Trust v S; R v Collins and others, ex parte S* [1998] 3 All ER 673(45), where the court held that:

> An unborn child, although human and protected by the law in a number of different ways, is not a separate person from its mother. Its need for medical assistance does not prevail over her rights, and she is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it.

Given this context, Australian courts are unlikely to authorise medical treatment on a competent, non-consenting pregnant woman.

3.3.2 Providing care without consent

In all situations where the woman has capacity, providing treatment without the consent of the woman may result in a criminal charge of assault, civil action for battery and/or disciplinary action.(11) Indicating to a woman that declining recommended care could lead to the involvement of the courts or child protection is likely to be coercive and may invalidate consent. An example includes performing an episiotomy for fetal heart rate decelerations without the woman's consent or with clear refusal of an episiotomy.

In an emergency situation, where the woman lacks capacity:

- medical treatment to preserve the woman's life may be initiated
  - however, clinicians should always consider known and clear directions given by the woman, when she had capacity. It may be necessary to comply with these directions
- refer to the Queensland Health *Guide to informed decision-making in health care*.(11)

3.3.3 Adverse outcomes and material risks

Many circumstances where recommended care is declined will not have adverse outcomes. However, perinatal outcomes may be significantly poorer where the woman:

- declines or delays CS(46), including emergency CS for abnormal fetal heart rate patterns with likely fetal compromise(47)
- declines blood products(46, 48) (this may also include Anti D immunoglobulin)
- discharges herself against medical advice during the antenatal(49) or postnatal(50) period (refer to Section 6.2 Keeping the woman engaged in maternity care)
- homebirths with identified obstetric risk factors (e.g. after 42 weeks gestation, with twins, breech presenting baby, vaginal birth after two caesarean sections) that are associated with higher rates of neonatal mortality.(51-54)

Clinicians owe a duty of care to ensure women are appropriately informed about care and treatment options being recommended for them and their fetus. Although the law recognises that a child has legal rights once born and has a separate existence from its mother, if a fully informed pregnant woman (with requisite capacity) experiences an adverse outcome as a result of declining recommended care and treatment, and where there is no evidence that the outcome was the result of any clinical negligence, the clinician will not be held liable for the relevant outcome (for the woman or any live children born as a result).

To be fully informed, the woman must have been informed about the material risks of her intended course of action. A risk is deemed ‘material’ when a reasonable person, in the patient's position would find that information important when making decisions about medical treatment (see *Rogers v Whitaker* [1992] HCA 58). The clinician should seek to give full advice about the material risks to the woman. Refer also the Queensland Health *Guide to informed decision-making in health care.*(11)

3.3.4 Additional advice

If required, health professionals may seek legal advice through the HHS’s usual arrangements after first consulting with the Executive Director of Medical Services or equivalent.

4 Roles and responsibilities

Each participant in maternity care has important responsibilities and accountabilities when a woman declines recommended care.

4.1 The woman's role and responsibilities

When declining recommended care, the woman is responsible for:

- making decisions that reflect her physical, social, emotional, psychological, spiritual and cultural needs
- the physical, social, emotional, psychological, spiritual and cultural outcomes that arise from her decisions, as well as her baby's outcomes
- being clear about planning "if, then" scenarios with the maternity care provider
  - in an emergency situation where there is a lack of capacity (refer to glossary for definition) and where the declined care may prevent usual emergency rescue efforts, the situation may be irretrievable and result in long term injuries or death.

To the extent that the woman wishes to do so, the woman may:

- actively participate in discussions regarding care options, risks, and benefits(6)
- amend a previous decision/plan
- seek support (e.g. partner) in her decision-making process
- maintain documentation, including:
  - the care that is being declined
  - reasons for declining
  - relevant information, evidence or concerns considered in decision-making
  - questions or concerns for discussion with the clinician
  - interest in seeking a second opinion
  - understanding of advice and answers to questions received from clinicians
  - the circumstances which would cause a review of her decisions
  - the Discussion and partnership care plan (Appendix B), Pregnancy Health Record (PHR)(56), or where not available, a local healthcare facility form/app or template such as the Australian College of Midwives' (ACM) Record of Understanding.(57)

4.2 Clinicians' roles and responsibilities

4.2.1 Communication

When partnering with the woman who declines recommended care, the clinician, within the context of local resources provided by the HHS, is responsible and accountable for:

- informing the woman about changes in clinical circumstances and explicitly communicating to the woman how these changing circumstances may, or are likely to, impact her or her baby's health
  - the woman may subsequently agree to review her previous decision/plan
- providing clear, unbiased, accurate, applicable, evidence-based, culturally appropriate and timely advice and answers to questions asked by the woman, including:
  - informing the woman she has the right to refuse treatment and withdraw consent at any time(6)
  - using language preferred by the woman (e.g. 'baby' rather than 'fetus')
  - offering relevant information (e.g. verbal, written, website link/s)
    - avoid sharing 'personal' views, beliefs and/or attitudes
  - seeking further professional support (e.g. legal where there are significant risks to declining)
  - recognising that refusal does not have to be fully informed and the woman may decline to participate in discussions about the risks and benefits of declining recommended care(6):
    - try to ensure the woman has sufficient information and understanding(11) to be able to waive the right to be fully informed
    - the woman may explain and/or document what she knows about the associated benefits and risks
    - offer the woman the opportunity to(6):
      - seek a second opinion or to discuss with another healthcare professional known to the woman
      - involve her family or other nominated support people in discussions
- referring to national and professional best practice clinical guidelines, such as:
  - Queensland Clinical Guidelines(58)
  - Australian Government pregnancy care guidelines and other pregnancy related information(1)
  - The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)(59)
  - Queensland Maternity and Perinatal Quality Council's Considerations in the management of pregnant women who refuse blood and blood products(60)
- cultural safety (refer to Section 2.1) and the use of interpreters (refer to Section 2.2)
- thorough documentation, including:
  - the information provided to the woman
  - the woman's decision to proceed with the care plan
  - inviting the woman to document (e.g. "I understand the risks in relation to this are…"; "I have received the [document name] information on the risk and benefits and understand the information"; or alternatively "I acknowledge I have declined to receive and discuss information on recommended maternity care and the reason for this is…")
  - documenting and signing by a clinical witness where applicable.

Further information on communication and documentation is provided in Section 5 Initial discussions.

4.2.2 Providing care

Providing care for the woman includes:

- demonstrating respect for the woman's decisions:
  - this builds mutual trust and can give the clinician credibility with the woman; this may assist with:
    - discussions, if risks associated with the woman's decisions eventuate(61)
    - avoiding conflict, which has arisen when women have declined recommended care(34, 38, 39), including in situations such as vaginal birth after caesarean section (VBAC)(62) and breech presentation(63), where women have faced considerable pressure to accept a CS
- declining to perform a requested procedure that they believe is unsafe, unnecessary and/or will do more harm than good (refer to Table 1 Four ethical principles)
- continuing to provide appropriate, respectful, attentive and woman-centred care to the woman throughout pregnancy, labour, birth and the postnatal period
  - ensure the woman is informed of this
  - it is not appropriate and is counterproductive to discharge a woman from the local health service for declining recommended care
- providing appropriate, respectful, attentive family-centred care for the woman's baby during the postnatal period, as per best practice
- reflective practice (e.g. considering potential unconscious biases)(38).

4.2.3 Consultation and referral

Consultation and referral considerations include:

- where required and available, arranging to hand over care to or seeking a second opinion from a colleague who may be more able and willing to provide continued care after the woman has declined recommended care
- assessing risk, escalating and implementing appropriate risk mitigation strategies as per local HHS Risk Management Framework and requirements with HHS executive support as required
- practicing according to:
  - the Clinical Services Capability Framework (CSCF)(18)
  - scope of credentialed and clinical practice, professional guidelines and codes, such as:
    - RANZCOG statement: Suitability criteria for models of care and indications for referral within and between models of care(64)
    - Medical Board of Australia: Good Medical Practice: a code of conduct for doctors in Australia(16)
    - ACM: National midwifery guidelines for consultation and referral(57)
    - National and Midwifery Board of Australia: Code of conduct for midwives.(17)

4.3 Hospital and health service roles and responsibilities

To enable a partnership, and to protect and support clinicians and the woman who declines recommended care, including when the woman or fetus is placed at increased risk, each HHS is responsible and accountable for:

- providing resources to enable the delivery of a safe and high quality maternity service(6)
- informing women of their healthcare rights, including the right to decline recommended care(3, 8)
- ensuring provision of endorsed culturally appropriate and evidence-based consumer information(6)
- implementing a process to effectively communicate about situations where women decline recommended care, including:
  - documenting, alerting and distributing the care plan to the necessary clinical staff and the woman
  - responding to reports of clinicians not supporting women who have declined recommendations
- ensuring clinicians have access to HHS endorsed best practice policy documents, including guidelines, procedures and clinical forms(19)
- ensuring that women who decline recommended maternity care continue to have access to holistic, supportive hospital services(6):
  - ensure transparency and accountability by documenting decisions about access(6)
- providing guidance, advice and support, as required by the clinician, during and after partnering with a woman who declines recommended care, including accessing:
  - HHS executive and legal advice
  - counselling services, particularly if an adverse outcome occurs
  - supportive collaborative pathways for timely and appropriate consultation, referral or transfer of women in private midwifery care
  - clinical supervision
- meeting requirements of the CSCF(18), including managing care in consultation with a higher level maternity service if clinical management is considered beyond a service's capability
- taking actions required to meet the ACSQHC's NSQHSS(19), particularly Standards:
  - 1 Clinical governance
  - 2 Partnering with consumers
  - 6 Communicating for safety
  - 7 Blood management
  - 8 Recognising and responding to acute deterioration
- assessing risk and implementing appropriate risk mitigation strategies as per local HHS and Queensland Health/Department of Health Risk Management Frameworks.(65)
- ensuring all staff understand that a care plan has been developed with senior staff and the woman.

5 Initial discussions

Whenever the woman expresses an intention to decline recommended care, even if early in pregnancy, initiate a two way dialogue.(34) The woman is most likely to be interested in alternatives to recommended care and is not declining all care.(66) Clinicians partnering with the woman are not necessarily endorsing the woman's choices, they are respecting the woman's right to decline care.(61) Also refer to Sections 4.1 The woman's role and 4.2 Clinicians' roles and responsibilities.

5.1 Supporting communication

To support effective woman-centred communication and decision-making:

- Provide a safe respectful place for the woman to discuss her concerns and needs.
- Minimise the number of clinicians directly involved with the woman in her care.
  - Where possible, invite the woman to access a continuity of care (CoC) model where stronger relationships and mutual trust may develop.
  - Alternatively, if CoC is not available, consider identifying one clinician within the health service to provide a navigation role.
- Consider health literacy level and use plain English.
- Seek resources and engage services where needed, including but not limited to:
  - Aboriginal and Torres Strait Islander Health Worker, Indigenous Liaison Officer (ILO), community health service (e.g. Ngarrama in the Metro North HHS)
  - interpreter services for women from culturally and linguistically diverse backgrounds (refer to Appendix A: Resources supporting culturally capable healthcare)
  - cultural support person
  - assistance for women with sensory impairment.
- Provide written and/or online/digital information, where available.(11)
- Consider audio-recording consultations (with the consent of all present and according to local facility policy). Audio-recordings may aid recall of information.(67) The woman and health service should both have access to any audio recording if requested.
- The woman should be offered(6):
  - a second opinion
  - inclusion of family members or support people of her choice in consultations.
- The clinician may wish to include another colleague in the discussions.
- Inform the woman of the Discussion and partnership care plan (refer to Appendix B) with questions she may like to consider including:
  - What is your understanding of the recommendation you have received?
  - Outline the aspects of recommended maternity care you are considering declining and why these are important to you.
    - This is particularly important for understanding the reasons why the woman may be declining recommended care.
  - What, if any, information have you already considered?
  - What, if any, concerns or questions would you like to discuss?
  - Following the initial discussions, What is your understanding of the information you have received from your maternity care provider?
- Document discussions including the resources used.

5.2 Reasons for declining recommended care

Discuss and document the woman's reasons for declining recommended care. The purpose of these discussions is not to judge the validity of the reasons, rather it:

- is a key component of supportive care interactions(38)
- may reveal ways to make aspects of recommended care acceptable to the woman(38, 66)
- may help clinicians to maintain respectful care practices(61, 66, 68)
- may help clinicians find out which risks may be material to the woman, and thus tailor discussions accordingly(69)
- may reassure clinicians that the woman has capacity to understand and make healthcare decisions
- may identify domestic and family violence (DFV) as the reason
  - discussions may need to take place in a private environment, alone with the woman, using sensitive inquiry (as provided in Queensland Health's DFV resources to support clinicians).(70)

5.3 Communicating benefits and risks

Discuss and document the benefits and risks to the woman and fetus of recommended care and alternatives (including the woman's intended care and the alternative of no treatment)(69, 71):

- Provide information to the woman in a way that they can understand(16, 71)
- Present evidence using absolute risk and benefit numbers in preference to relative risk and benefit numbers(71, 72) (refer to Glossary) and percentages(71); for example, it is preferable to express risk as:
  - increasing from a 1 in 1000 risk to a 2 in 1000 risk, rather than:
    - × doubling the risk
    - × increasing the risk by 100%
    - × increasing the risk from 0.1% to 0.2%
    - × comparing 1 in 1000 to 1 in 500 risk.

- Consider framing effects of how evidence is presented, as this may influence the woman's decision, and present in balanced (e.g. both gain and loss) and neutral terms where possible(71), for example, risk may be expressed as:
  - 20 in 100 women experience complications, then also say that 80 in 100 have no complications.
- Develop 'if, then' scenarios and plans for emergencies so that the woman's wishes are known.(38)

5.4 Maternity care planning

A jointly developed plan for the woman's ongoing maternity care may be discussed and planned over more than one appointment. This is to enable the woman and clinician to consider information exchanged and consultation with others as appropriate.

In planning the woman's maternity care, discuss and document:

- advice sought from colleagues (e.g. midwifery, obstetrics, Maternal Aboriginal & Torres Strait Islander Health Worker and/or ILO, anaesthetics, neonatology/paediatrics, maternal fetal medicine, General Practitioner (GP), social work, ethics, cultural support worker, perinatal mental health, HHS executive and/or legal services) and actions taken as a result
- multi-disciplinary team meetings including with the woman and senior clinicians and the Clinical Director of Maternity Services (or equivalent)
- what the woman consents to
- where relevant, measures that may improve potential outcomes, such as:
  - an increased schedule of antenatal visits
  - additional monitoring
  - additional care for the woman who declines blood products(66)
- alert and distribute the care plan, to the necessary clinical staff (e.g. labour ward where required) and the woman.

5.4.1 Care plan review

Review plans whenever the woman's intentions, clinical indications or circumstances change, and reconfirm upon admission for birth:

- Give the woman time to make a decision.(11)
- Document either her revised intentions or her continued adherence to documented plan.
- In the absence of new clinical indications or changing circumstances, repeatedly reviewing risk information with the woman could be coercive and is inconsistent with woman-centred care.(38)

5.5 Documentation

Record documentation in the woman's PHR and/or pregnancy progress notes, with copies provided to the woman, her midwife and/or GP, as appropriate:

- Where required, scan documentation as soon as possible into the electronic medical record system.
  - The Discussion and partnership care plan (refer to Appendix B: Discussion and partnership care plan) is scanned to Clinical Notes View / Pathways-Care Plans / Care plans in the Queensland Health integrated electronic medical record (ieMR).
- A documentation template is available in Appendix B: Discussion and partnership care plan.

5.6 Follow up

Following initial discussions with the woman, and where the woman's intended course of action poses risk of serious harm to the woman or fetus (or baby after birth):

- consult with an appropriate senior clinician or colleague (either within the facility or at a referral hospital)
- refer to Section 6 Follow up discussions.

6 Follow up discussions

After initial discussions between the woman and clinician, all parties will have a better understanding of the woman's pregnancy and/or birth intentions and the reasons for them. An agreed way forward may have been identified. If not, an appropriate senior clinician can review documentation of the initial discussions to inform risk analysis and mitigation. To do this, the senior clinician may consult:

- further with the woman
- with colleagues (e.g. midwifery, obstetrics, Maternal Aboriginal & Torres Strait Islander Health Worker and/or ILO, anaesthetics, neonatology/paediatrics, maternal fetal medicine, social work, ethics, cultural support worker, perinatal mental health, GP, HHS executive and/or legal services)
- the Director of Service including where clinicians are in disagreement.

Through risk analysis and mitigation, risks may not be eliminated. However, risks should be managed to a level as low as reasonably practicable. Risks may be tolerable (able to be accepted without further response) if(73):

- further risk reduction is impractical
- cost of further risk reduction would exceed the improvements/benefits gained
- no treatment/control has been responded to or is available.

Following risk analysis and mitigation, the residual risk guides the level of planning, support and documentation required. Refer to local HHS requirements. However, as a general guide, if there is:

- low–medium residual risk: documentation of the care plan in the woman's chart and discussion with the senior clinician may be sufficient
- medium–high residual risk: development of an agreed care plan which is preferably signed by the senior clinician and the woman may be sufficient (refer to Section 6.1 Partnership care plan)
- a notable complexity of risk above the recommended care which may include a high–very high residual risk:
  - consultation with HHS executive is necessary where the potential for major or extreme consequences (e.g. permanent harm or loss of life) is likely or almost certain
  - HHS legal services and/or ethics support may be required to assist with planning
  - a partnership care plan may also be developed (refer to Section 6.1 Partnership care plan).

6.1 Partnership care plan

To ensure the woman has access to holistic, supportive maternity care irrespective of her pregnancy and birth intentions, a partnership care plan may be jointly developed by the woman and clinicians when:

- despite risk management measures, the level of residual risk is considered medium to very high
- the woman, clinician or another health care professional involved in the woman's maternity care, considers additional documentation, including beyond declining recommended maternity care discussions, is required.

Where a partnership plan (refer to Appendix B: Discussion and partnership care plan) is developed:

- Document:
  - the recommended care being declined
  - the care plan
  - the risks and benefits of the care plan
  - when the plan should be reviewed.
- Review the relevant declaration section prior to signing.
- Clinicians to circulate to all hospital clinicians who may be involved in the woman's subsequent maternity care, in order to(34, 66):
  - establish a respectful atmosphere in future clinical encounters and prevent the woman from having to 'tell her story' repeatedly
  - improve communication and discussion amongst clinicians
  - respect each clinician's own autonomy
  - assist in clinically supporting clinicians
  - improve the quality of documentation over time.
- Clinicians to add the plan to the PHR, with copies provided to the woman, her midwife and/or GP
  - ensure the plan is easily identifiable in the woman's records
  - where applicable, document or promptly scan the plan into the electronic medical record system
    - Queensland Health ieMR [Cerner]:
      - Manually add a clinical alert
      - The Discussion and Partnership Care Plan is scanned to Clinical Notes View / Pathways-Care Plans / Care plans.

6.2 Keeping the woman engaged in maternity care

Keeping the woman engaged in hospital maternity services, even if this means not providing recommended care, is considered a harm minimisation measure.(30, 61, 74, 75) Women who would prefer to avoid aspects of routine maternity care may not overtly decline. Concerns about conflict with clinicians may lead women to 'selective telling(76), 'tactical planning(77), missing appointments(78) or other disengagement from hospital maternity care.(79)

6.2.1 When the woman is concerned about the process

Where the results of the planning discussions with the clinicians have not been acceptable to the woman:

- ensure the woman is provided with information on the facility's feedback (complaints) procedure.

The next steps, for the woman, may include:

1. Provide feedback to the midwifery manager or GP/obstetric director of the maternity service. If the concerns are not resolved in a timely manner, proceed to the next step.
2. Formalise the issue with the Patient Liaison Officer (PLO) or local facility equivalent. Due to the time limitations associated with pregnancy, contacting the PLO in person may be more efficient, as this level of response is more involved, and it may take some time to address the concern. The PLO will liaise with the woman and relevant maternity clinicians.
3. If the concerns are not resolved in a timely manner, refer to the HHS complaints coordinator, who reviews feedback for all health facilities in the area.
4. If the concern is not addressed, the matter can be taken outside of the HHS to the Queensland Government Office of the Health Ombudsman.

6.2.2 Disengagement from public hospital maternity care

If the woman disengages from maternity care provided by the hospital:

- consider if the woman's actions are an expression of declining recommended care
- contact the woman to discuss her needs and look for acceptable options; ask 'What could we [the health service] do to enable you to feel safe to access care here?':
  - follow through with genuine options
- inform the disengaged woman about:
  - this guideline and the option to make a plan with her maternity care providers
  - her right to refuse recommended care and still receive safe, supportive health care
- involve other healthcare professionals and/or health service providers as required (e.g. GP, social worker)
- refer to local policy for women who disengage from healthcare.

7 During labour and birth

7.1 Admission

When the woman presents in labour, reconfirm the plan with the woman:

- Discuss and understand any new clinical or operational circumstances.
- Document the woman's intention to continue as planned or revise the plan.
- Inform relevant clinicians, and, as required, the hospital executive that the woman has been admitted.
- Maintain communication and seek support from other clinicians and the hospital executive, as required.

7.2 Care declined for the first time

The woman may decline care for the first time after labour has commenced:

- A condensed planning approach may be necessary to elicit the woman's perspective.
- As required:
  - discuss, refer and/or consult
  - seek support from colleagues, the health service executive
  - in rural or remote facilities:
    - refer to the Primary Clinical Care Manual(80)
    - contact Retrieval Services Queensland as per usual procedures.
- Maintain documentation.

Refer to Flow chart: Partnering with the woman who declines recommended maternity care in an emergent situation and/or in labour and is declining care that has not previously been discussed.

7.3 Deteriorating clinical circumstances

Refer to Section 8 Emergent situation.

7.4 Following birth

Following birth and during the postnatal period, the woman may decline further aspects of recommended care (e.g. active management of the third stage of labour, perineal repair).

8 Emergent situation

It is extremely unusual for a woman to continue to decline recommended care in deteriorating clinical circumstances. Such situations are best dealt with on a case by case basis,(81) and within the context of valid consent (refer to Section 3) and the woman's right to decline recommended care by:

- continuing to clearly inform the woman about the changing clinical circumstances including:
  - the urgency of the situation
  - how these changing circumstances may or are likely to impact her or her baby's health and wellbeing, including the risks of declining recommended care
  - the rationale of recommended care
- respectfully ensuring the woman understands that while clinicians will always do their best to provide life-saving care to her and her fetus, if that is delayed too long then permanent harm to the woman and/or fetus may not be avoidable
- providing, wherever possible, continuity of carer for the woman to feel safe and confident in her care, and to promote an environment of partnership and shared dialogue
- where possible, reducing the number of clinicians in the birth room, or where the woman may be, as this may reduce tension and support more effective and calm communication with the woman and the physiology of labour
- offering to contact a consumer liaison/advocate (e.g. Aboriginal and Torres Strait Islander Health Worker, ILO)
- being prepared to act immediately should the woman change her mind and wish to review alternative care options that may further minimise risk, or have more information to make choices which may or may not be in line with recommended care
- informing and seeking support from colleagues as required (e.g. notifying neonatologist/paediatrician, Retrieval Services Queensland, hospital executive)
- involving the senior leadership team for obstetrics and midwifery
- assigning a clinician to the scribing role to assist in documentation of the above
  - woman-centred care is best supported by assigning a clinician to the scribing roll thus enabling other clinicians to focus on communicating with and caring for the woman.

Refer to Flow chart: Partnering with the woman who declines recommended maternity care in an emergent situation and/or in labour and is declining care that has not previously been discussed.

9 Follow-up care

For the woman who declined recommended care, her follow-up care may:

- be routine (e.g. where there has been no adverse sequelae)
- be provided in the context of good or poor maternal or fetal outcomes
- involve the woman declining further aspects of recommended care.

9.1 Supporting the woman

During the postnatal period the woman may wish to discuss her experience with the clinicians involved in her care, particularly where her intentions changed and consent was given to a higher level of intervention than anticipated. Such discussion should be:

- preferably with the primary clinician involved in the woman's care and at an appropriate time (e.g. not when the woman is in pain or fatigued, or when the clinician is feeling rushed)
- deferred to a later date, if the woman prefers, and with an open ended invitation at any future time to discuss
- held over several sessions, where required
- inclusive of support people, if the woman prefers
- including:
  - acknowledgement if there were no adverse outcomes from declining care
  - any labour and birth concerns (including unplanned events)
  - identification of emotional needs
  - reason for the unplanned events or interventions
  - any implications for future pregnancies and births, including how future birth could be planned
  - information on the facility's feedback (complaints) procedure, where required
- documented and shared with the woman, midwife and GP, as applicable.

9.1.1 When there is a poor outcome

If there is a poor outcome the woman may feel guilty about her decision/s. As well as the discussion points above:

- actively listening to the woman
- do not engage in judgemental and punitive interactions as it may harm the woman(12), and have lasting negative implications (e.g. the woman withdrawing from further recommended health care)
- communicate honestly and compassionately with the woman, including acknowledging that:
  - medical decision-making is complex and well-intentioned people can make decisions they later regret(12), acknowledging that 'you made, what you thought, was the best decision for you and your baby, at the time, in your situation'
  - the adverse outcome was not a certainty(12)
- assist with Open Disclosure processes as required (refer to Queensland Health Open Disclosure Resources(82))
- make counselling resources available to the woman.

10 Supporting clinicians

Clinicians involved in the care of the woman who declines recommended care may:

- feel frustrated if they perceive that the woman is ignoring their concerns about her wellbeing and the wellbeing of her fetus
- be concerned about medico-legal issues(31-36) (although support for clinicians will be in place under the usual indemnity policies), including:
  - limiting their capacity to provide safe care, and possible contribution to poor outcomes for the woman and/or her fetus
  - providing care that is outside their scope of practice or outside the clinical services capability of the health service
- feel grief, anger and distress, especially in the event of poor outcomes or near misses
- worry about the woman's reaction if her decision to decline recommended care contributes to a poor outcome
- disagree about the responsibilities of different clinicians involved in the woman's care
- be concerned about continuing their care where other team members are unwilling to support the woman's care, including apprehension about complaints being made against them to the Australian Health Practitioner Regulation Agency.

To support clinicians in these situations, HHSs should:

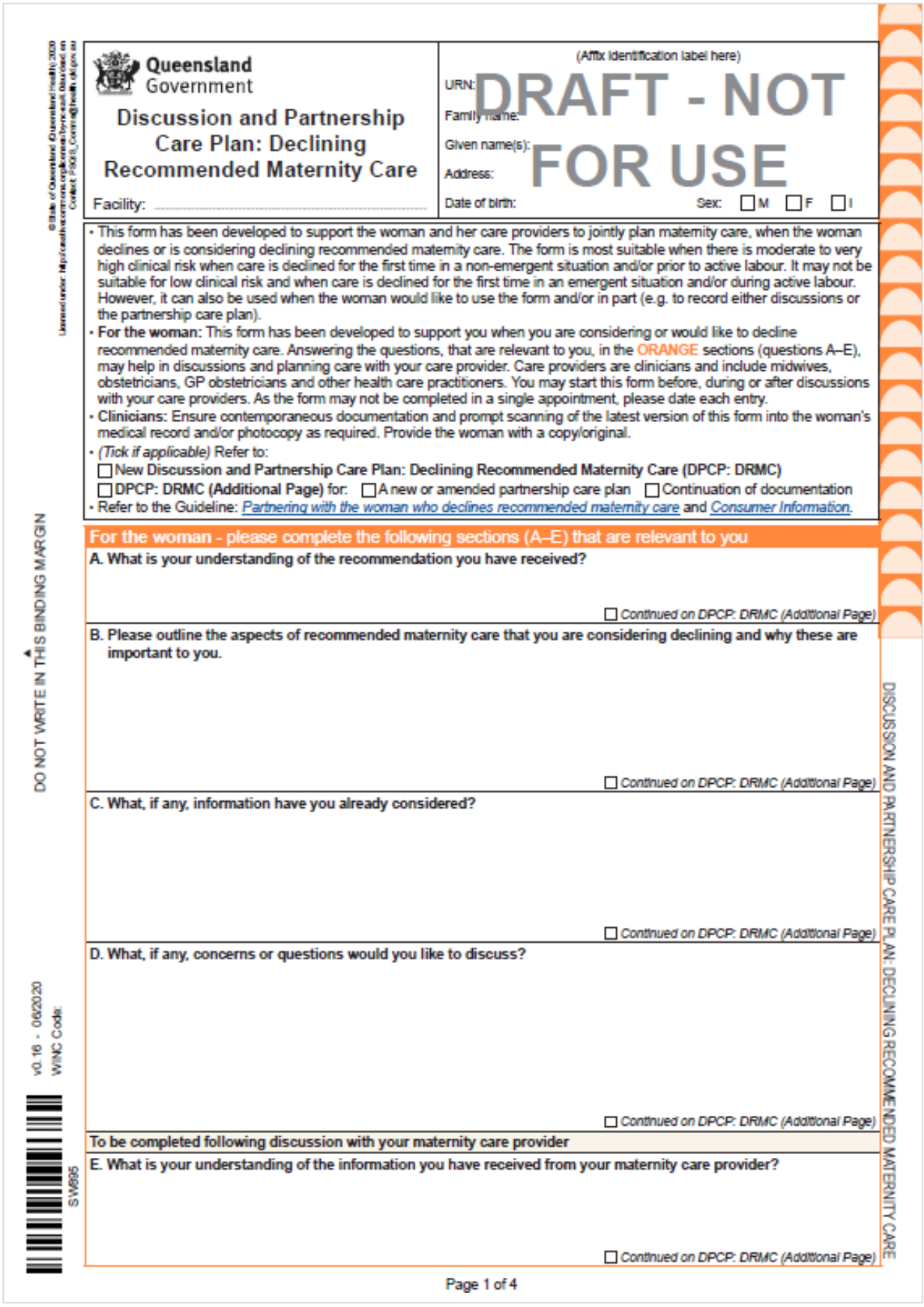
- ensure clinicians have immediate and ongoing access to guidance, advice and support, including counselling and debriefing services, executive team, and legal as required
- assist with Open Disclosure processes as required (refer to Queensland Health Open Disclosure Resources(82))
- evaluate the development and implementation of risk mitigation strategies, and determine if lessons can be learned, for future partnerships with women and other members of the health care team.

Appendix A: Resources supporting culturally capable healthcare

Resources supporting culturally capable healthcare (Queensland Health)	
Resources and web address	**Content**
Aboriginal and Torres Strait Islander patient care guideline(83) www.health.qld.gov.au/atsihealth	General advice to support healthcare staff in delivering safe, clinically and culturally responsive care.
Considerations in the management of pregnant women who refuse blood and blood products(60)	Queensland Maternal and Perinatal Quality Council
Multicultural health www.health.qld.gov.au/multicultural	A range of resources to support the healthcare of culturally and linguistic diverse people.
Multicultural health: a guide for health professionals www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide	Includes community profiles for healthcare providers for the following communities: • Afghan • Australian South Sea Islander • Burmese • Burundian • Cambodian • Chinese • Ethiopian • Filipino • Hmong • Indian • Iraqi • Japanese • Maori • Papua New Guinean • Samoan • Sri Lankan • Sudanese • Vietnamese.
Multicultural clinical support resource www.health.qld.gov.au/multicultural/health_workers/support_tools	The folder includes chapters on communication, interpreting, health and religion, multicultural contacts, and pregnancy, birth and post-natal care; as well as the handbooks below.
• **Cultural dimensions of pregnancy, birth and post-natal care** www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide	Contains cultural assessment questions, concomitant conditions and cultural groups, female genital mutilation, psychological and social issues relating to pregnancy and early parenthood and cultural profiles including: • Burmese • Chinese • Fijian • Filipino • Japanese • Indian • Papua New Guinean • Malaysian • Samoan • Sudanese • Vietnamese.
• **Health Care Providers' Handbook for Hindu Patients** www.health.qld.gov.au/multicultural/health_workers/support_tools	Includes Hindu beliefs affecting health care.
• **Health Care Providers' Handbook for Sikh Patients** www.health.qld.gov.au/multicultural/health_workers/support_tools	Includes Sikh beliefs affecting health care.
• **Health Care Providers' Handbook for Muslim Patients** www.health.qld.gov.au/multicultural/health_workers/support_tools	Includes Islamic beliefs affecting health care.

Appendix B: Discussion and partnership care plan

For current version, refer to Queensland Health Informed Consent www.health.qld.gov.au/consent



Queensland Government

Discussion and Partnership Care Plan: Declining Recommended Maternity Care

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Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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- This form has been developed to support the woman and her care providers to jointly plan maternity care, when the woman declines or is considering declining recommended maternity care. The form is most suitable when there is moderate to very high clinical risk when care is declined for the first time in a non-emergent situation and/or prior to active labour. It may not be suitable for low clinical risk and when care is declined for the first time in an emergent situation and/or during active labour. However, it can also be used when the woman would like to use the form and/or in part (e.g. to record either discussions or the partnership care plan).
- **For the woman:** This form has been developed to support you when you are considering or would like to decline recommended maternity care. Answering the questions, that are relevant to you, in the ORANGE sections (questions A–E), may help in discussions and planning care with your care provider. Care providers are clinicians and include midwives, obstetricians, GP obstetricians and other health care practitioners. You may start this form before, during or after discussions with your care providers. As the form may not be completed in a single appointment, please date each entry.
- **Clinicians:** Ensure contemporaneous documentation and prompt scanning of the latest version of this form into the woman's medical record and/or photocopy as required. Provide the woman with a copy/original.
- *(Tick if applicable)* Refer to:
  ☐ **New Discussion and Partnership Care Plan: Declining Recommended Maternity Care (DPCP: DRMC)**
  ☐ **DPCP: DRMC (Additional Page)** for: ☐ A new or amended partnership care plan ☐ Continuation of documentation
- Refer to the Guideline: *Partnering with the woman who declines recommended maternity care* and *Consumer Information*.

For the woman - please complete the following sections (A–E) that are relevant to you

A. What is your understanding of the recommendation you have received?

☐ *Continued on DPCP: DRMC (Additional Page)*

B. Please outline the aspects of recommended maternity care that you are considering declining and why these are important to you.

☐ *Continued on DPCP: DRMC (Additional Page)*

C. What, if any, information have you already considered?

☐ *Continued on DPCP: DRMC (Additional Page)*

D. What, if any, concerns or questions would you like to discuss?

☐ *Continued on DPCP: DRMC (Additional Page)*

To be completed following discussion with your maternity care provider

E. What is your understanding of the information you have received from your maternity care provider?

☐ *Continued on DPCP: DRMC (Additional Page)*

DO NOT WRITE IN THIS BINDING MARGIN

DISCUSSION AND PARTNERSHIP CARE PLAN: DECLINING RECOMMENDED MATERNITY CARE

v0.16 - 062020 WMC Code: SW895

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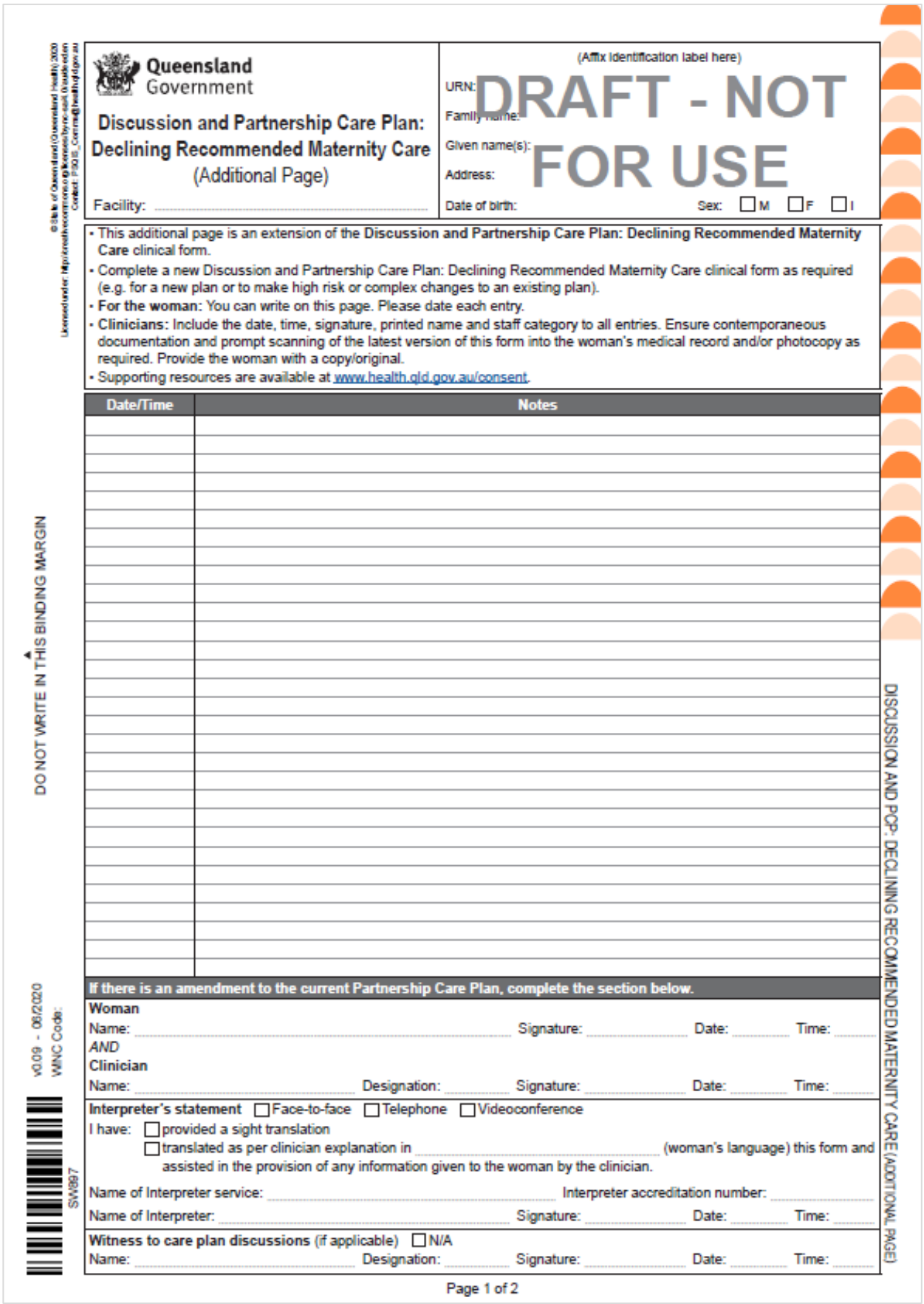
Discussion and partnership care plan: additional page



Queensland Government

Discussion and Partnership Care Plan: Declining Recommended Maternity Care
(Additional Page)

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- This additional page is an extension of the **Discussion and Partnership Care Plan: Declining Recommended Maternity Care** clinical form.
- Complete a new Discussion and Partnership Care Plan: Declining Recommended Maternity Care clinical form as required (e.g. for a new plan or to make high risk or complex changes to an existing plan).
- **For the woman:** You can write on this page. Please date each entry.
- **Clinicians:** Include the date, time, signature, printed name and staff category to all entries. Ensure contemporaneous documentation and prompt scanning of the latest version of this form into the woman's medical record and/or photocopy as required. Provide the woman with a copy/original.
- Supporting resources are available at www.health.qld.gov.au/consent.

Date/Time	Notes

If there is an amendment to the current Partnership Care Plan, complete the section below.

Woman
Name: ..... Signature: ..... Date: ..... Time: .....
AND
Clinician
Name: ..... Designation: ..... Signature: ..... Date: ..... Time: .....

Interpreter's statement ☐ Face-to-face ☐ Telephone ☐ Videoconference
I have: ☐ provided a sight translation
☐ translated as per clinician explanation in ..... (woman's language) this form and assisted in the provision of any information given to the woman by the clinician.
Name of Interpreter service: ..... Interpreter accreditation number: .....
Name of Interpreter: ..... Signature: ..... Date: ..... Time: .....

Witness to care plan discussions (if applicable) ☐ N/A
Name: ..... Designation: ..... Signature: ..... Date: ..... Time: .....

Page 1 of 2

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DISCUSSION AND PCP: DECLINING RECOMMENDED MATERNITY CARE (ADDITIONAL PAGE)

v0.09 - 06/2020
WNC Code:
SW887

Abbreviations

Term	Definition
ACM	Australian College of Midwives
ACSQHC	Australian Commission on Safety and Quality in Health Care
CEQ	Clinical Excellence Queensland
CS	Caesarean section
CSCF	Clinical services capability framework
DFV	Domestic and family violence
GP	General Practitioner
HHS	Hospital and Health Service
ieMR	Integrated electronic medical record
ILO	Indigenous Liaison Officer
NSQHSS	National Safety and Quality Health Service Standards
PHR	Pregnancy Health Record
PLO	Patient Liaison Officer
PSQ	Patient Safety and Quality, Clinical Excellence Queensland
SA	South Australia
Qld	Queensland
RANZCOG	The Royal Australian College of Obstetricians and Gynaecologists
VBAC	Vaginal birth after caesarean section

Glossary

Term	Definition
Absolute risk	The likelihood of an event or health outcome occurring in a group of people under specific conditions.(84) Means the same as 'incidence' and 'actual risk'.
Best practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide practitioner and patient decisions about appropriate health care in specific clinical practice settings and circumstances.(85) The above definition is also used by the ACSQHC's NSQHSS.(19)
Clinician	A health practitioner, trained as a health professional, providing direct clinical care,(11) and health care students who provide health care under supervision.
Capacity	The person is capable of(11): • understanding the nature and effect of decisions about a matter • freely and voluntarily making decisions about a matter • communicating the decision in some way
Informed consent	For consent to be informed, the woman needs to be fully aware and have an understanding of the condition, the nature and purpose of the available and proposed health care, and the potential consequences of each option. Furthermore, the woman should be aware of what is likely to occur should they choose not to receive the health care. This results from the provision of information in a manner appropriate to the needs of an individual woman, in the absence of coercion by any party, that reflects self-determination, autonomy and control.(11)
Material risk	Information about the risks of healthcare that: • a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to receive the healthcare or follow the advice; and • the health practitioner knows or ought reasonably to know the patient wants to be given before making the decision about whether to receive the healthcare.(11)
Maternity care	Antenatal, intrapartum and postnatal care for pregnant women and babies up to six weeks after birth.(86)
Open disclosure	The open discussion of incidents that result in harm to a patient while receiving healthcare with the patient, their family, carers and other support persons.
Relative risk	Also known as a risk ratio. The probability of an event (risk) occurring in the exposed (study) group compared to the probability of the same event occurring in the non-exposed (control) group. The risk is expressed as a ratio.(84) To understand the implications of relative risk and the woman's likelihood of developing a health condition, absolute risk numbers are required.
Residual risk	The risk that is left over following completion of actions to modify the initial risk. Often referred to as retained risk.
Safe and high quality care	Care is consumer-centred, driven by information, and organised for safety.(19)
Senior clinician	Facilities will assign the role of senior clinician according to their local or HHS requirements. However, it is likely senior clinician will refer to at minimum a senior medical officer with specialist training in obstetrics.
Treatment	The provision of a service or a procedure to diagnose, maintain or treat a physical or mental condition and carried out by, or under the direction or supervision of, a health provider.(11)
Woman-centred care	Care that is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self determination in terms of choice, control, and continuity of care.(9)

Version history

Version	Date	Changes
Version 1.0	July 2020	First Version
Version 1.1	February 2025	Changes made to Section 3.3 The woman's right to decline recommended care.

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Working Group Co-Leads
Dr Bec Jenkinson (PhD), Consumer Representative
Professor Rebecca Kimble, Medical Lead Quality Improvement, CEQ, Queensland Health, Pre-eminent Specialist Obstetrician and Gynaecologist, Royal Brisbane and Women's Hospital

Working Group Members
Mr Istalin Ahmed Ismail, Consumer Representative, Refugee Health Network Queensland
Dr Fatima Ashrafi, Locum Consultant Obstetrics and Gynaecology, Mt Isa Hospital
Ms Rukhsana Aziz, Clinical Midwifery Consultant, Ipswich Hospital
Dr Stephanie Azri (PhD), Consumer Representative
Ms Josephine Bell, Midwife, Stanthorpe Hospital
Dr Margaret Bickerstaff, Consultant Obstetrician, Bundaberg Hospital
Mrs Anne Bousfield, Clinical Midwifery Consultant, South West Hospital Health Service
Dr Paul Bretz, Director of Obstetrics & Gynaecology, Mater Health Services, Brisbane
Dr Anthony Brown, Director of Medical Services, North, Thursday Island Hospital
Ms Tanya Capper, Acting Head of Program (Midwifery), Central Queensland University
Ms Sharon Chambers, Clinical Midwife and Credentialed Diabetes Educator, Royal Brisbane and Women's Hospital
Ms Vidya Charan Jeeva, Consumer Representative
Ms Anne Clayton, Nursing & Midwifery Director, Caboolture Hospital
Dr Jan Connors, Director Child Protection and Forensic Medical Services, Children's Health Queensland HHS
Dr Lucy Cooke, Director of Neonatology, Mater Misericordiae Ltd
Ms Jade Cooper, Midwife, Royal Brisbane and Women's Hospital
Ms Belinda Costello, Consumer Representative
Ms Jo Cowper, Consumer Representative
Dr Petrina Duncan, Staff Specialist Obstetrics and Gynaecology, Royal Brisbane and Women's Hospital
Dr Hasthika Ellepola, Staff Obstetrician, Logan Hospital
Professor David Ellwood, Professor of Obstetrics and Gynaecology, Griffith University
Dr Coralie Endean, Rural Generalist, Stanthorpe Hospital
Mr Peter Farley, [Former] Chief Legal Counsel, Queensland Health
Ms Debby Gould, Consumer Representative, BirthTalk
Ms Josie Greaves, Midwife, Sunshine Coast University Hospital
Ms Jacqueline Griffiths, Acting Regional Maternity Services Coordinator, Cairns and Hinterland HHS
Mr Michael Hall, Clinical Midwife, Beaudesert Hospital
Ms Leah Hardiman, Consumer Representative, Maternity Choices Australia
Mr Charles Hartley, Head of Legal Services, Metro North HHS
Ms Merewyn Janson, Clinical Midwife, Midwifery Group Practice, Beaudesert Hospital
Ms Meredith Lovegrove, Midwife, Rockhampton Hospital; Queensland representative, Australian College of Midwives
Dr Simon Maffey, Deputy Director Obstetric Anaesthesia, Mater Health Services, Brisbane
Dr Belinda Maier, Professional Officer, Queensland Nurses and Midwives Union
Ms Sue McPherson, Nurse Practitioner Midwife, Mackay Hospital and Health Service
Ms Debbie Mitchell, Maternity Educator, Emerald Hospital
Ms Madeline Mitchell, Social Worker, Ngarrama Family Health Project Team, Metro North HHS
Mrs Mina Mohammad Pour, Consumer Representative
Ms Amanda Ostrenski, Midwifery/Nursing Director, The Townsville Hospital
Ms Suzanne Pepper, Registered Midwife, Warwick Hospital
Dr Scott Petersen, Staff Specialist Maternal Fetal Medicine, Mater Health Services, Brisbane
Dr Lyndal Phelps, Rural Generalist, Stanthorpe Hospital
Queensland Clinical Guidelines team, Queensland Health
Ms Elisha Rasleigh, Consumer Representative
Dr Rachel Reed, Senior Lecturer in Midwifery, University of the Sunshine Coast
Ms Deann Rice, Clinical Midwife Consultant, Royal Brisbane and Women's Hospital
Ms Elizabeth Rigg, Senior Lecturer in Midwifery, University of Southern Queensland
Dr Thangeswaran Rudra, Senior Staff Obstetrician, Royal Brisbane and Women's Hospital
Ms Latisha Ryder, Consumer Representative, Maternity Consumer Network
Ms Teresa Sander, Midwife, Rockhampton Hospital
Mrs Trish Smith, Acting Nursing and Midwifery Director, Royal Brisbane and Women's Hospital
Ms Alecia Staines, Consumer Representative, Maternity Consumer Network
Dr Jocelyn Toohill, Director of Midwifery, Office of the Chief Nursing and Midwifery Officer, Queensland Health
Dr Clare Walker, GP Obstetrician, A/Director of Medical Services, Roma Hospital
Ms Lilian Wamucii Wangechi, Consumer Representative

Ms Samantha Watson, Advanced Health Worker, West Moreton HHS
Dr Chris Weekes, Senior Medical Officer, Caboolture Hospital
Ms Caroline Whitworth, Clinical Nurse Consultant, Child Protection Unit, Townsville HHS
Dr Lynn Woodward, Senior Lecturer, School of Medicine and Dentistry, James Cook University

Trial sites
Emerald Hospital
Mt Isa Hospital
Thursday Island
Rockhampton Hospital
Royal Brisbane and Women's Hospital
Wide Bay Hospital and Health Service

2020 Legal review
Legal Branch, Queensland Health

Maternity Services Action Group 2 Leadership Group
Associate Professor Rebecca Kimble, Co-Chair, Medical Lead Quality Improvement, CEQ, Queensland Health
Ms Kirstine Sketcher-Baker, Co-Chair, Executive Director, Patient Safety and Quality (PSQ), CEQ, Queensland Health
Dr Anthony Brown, Director of Medical Services, Thursday Island Hospital
Professor David Ellwood, Professor of Obstetrics and Gynaecology, Griffith University
Dr Bec Jenkinson, Consumer Representative
Ms Amanda Ostrenski, Midwifery/Nursing Director, The Townsville Hospital

Principal Project Officer
Lyndel Gray, PSQ, CEQ, Queensland Health

Maternity Services Action Group 2 Project Team
Mrs Karissa Burley, Manager, Support Unit, PSQ, CEQ, Queensland Health Ms
Carolyn James, Principal Project Officer, PSQ, CEQ, Queensland Health

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