Rural Obstetric Services:

By whom, how and where will we be delivering babies in 20 years' time?

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Provision of maternity care services in Australia and New Zealand is changing with the disappearance of the health care services based on care in local communities, provided by long-term resident family doctors and midwives working in small community hospitals. Looking ahead to rural maternity care in 20 years' time, it is pertinent to consider changes which might influence the picture and those things which will remain the same.

Factors which will not change include the innate unpredictability of the outcome of any individual pregnancy and the ultimate reliance of maternity care services on fallible human beings. The epidemiology of pregnancy complications and economic reality will also continue to dictate the centralisation of tertiary care services. Rural areas will remain dependent on good roads to enable access to local health care services, and efficient air and road ambulance services to access central services. Population projections also suggest that the number of women of child bearing age, and the number of babies born in any given year will not likely change significantly in the next 20 years[1].

Some areas of change which may influence the way maternity services are provided include the increasing sophistication of telecommunications and population drifts away from marginal farming and pastoral areas toward larger rural centres and coastal communities[2]. The life-style expectations of health care providers and their families, together with an increasing emphasis on safe work practices are already seeing a move away from solo general and specialist practice toward group practice and shared on call arrangements. This trend will almost certainly continue and will contribute to trend toward consolidation of obstetric hospital services in larger rather than smaller rural population centres.

Provision of antenatal care for women living in remote circumstances will become an increasing financial strain on families if such care remains dependent on women travelling significant distance to see their antenatal care team. If successive governments hold to their word on providing access for rural communities to state-of-the-art telecommunications, many antenatal consultations could be conducted with video link 'face-to-face' meetings between patient and doctor/midwife team. Women could use home based electronic blood pressure monitoring, hand held fetal heart rate Doppler monitors, urine dip sticks, and those high-tech instruments, the bathroom scales and a tape measure to provide the information we currently collect at antenatal visits. Antenatal education could be facilitated by similar means.

The geography of Australia and New Zealand has long necessitated that rural health care workers expeditiously identify those patients who may need the services of regional or tertiary hospitals. This is possible to an extent now, but sometimes at the cost of much disruption to rural family life. Ultrasound assessment of cervical length and cervical fetal fibronectin testing have improved our capacity to predict which patients with threatened preterm labour need transfer to centres with the appropriate resources to care for premature babies. Many women are still transferred unnecessarily. Twenty years hence may see more refined biochemical markers to identify those at risk, perhaps more reliable tocolytics that will arrest preterm labour until a safe gestation is reached and the tools to more accurately identify those pregnancies where tocolysis and prolongation of pregnancy is in the baby's and mother's long term interest[3].

As now, there will remain a small group of women where even antenatal care at distance from comprehensive maternal and neonatal hospital facilities is considered high risk and much of the second half of pregnancy will have to be spent away from home. A wish list for the

future would include government funding to support families caught in this situation. A decision which affects a far greater number of women living beyond a safe distance to travel in labour is: When to relocate to await the birth of their child? Without reliable predictors of when labour is likely to occur this may mean planning for up to eight weeks or more away from home. Little wonder that requests for a date for induction of labour or elective caesarean section for social reasons are not uncommon from such women and their partners. With little advance on the poorly predictive Bishop's score for estimating timing of onset of labour at term, [4] perhaps we will have to wait longer than 20 years before this riddle is solved.

Unless our ability to predict the unexpected in labour improves considerably, it is unlikely that there will be any significant change in the majority preference for hospital based intrapartum care services. With approximately eight per cent of pregnancies assessed as low risk being complicated by a potentially life threatening emergency in labour, [5] it is difficult to imagine many women giving birth to their first baby, or their first of two, in their mid-30s, choosing to deliver in an environment where easy resort to emergency medical expertise and caesarean section is not available.

On an optimistic note, the staffing of those community hospitals which do survive, and have the workload to sustain the staffing and facilities required to offer a comprehensive maternity service, are likely to have an easier time finding skilled medical practitioners than they do today. By 2026 in Australia, the benefits of recent changes in government policy should be apparent. These include a significant increase in medical graduate numbers before the end of the decade, the recruitment of rural students into medical schools and the implementation of a rural bonded scholarship scheme. The increasing influence of the Australian College of Rural and Remote Medicine encouraging the training of general practitioners with procedural skills in obstetrics and anaesthetics should also help sustain rural maternity services. To complement the predicted increase in medical staff numbers, work may need to be done in recruiting and retaining midwives to an area of work which will almost always require an ongoing commitment to working family unfriendly hours[6].

All of the above is contingent on maternity services being able to successfully recruit from the increasing graduate pool, and retain a new generation of workers. Recent trends in recruitment may be encouraging but it is yet to be seen whether this will lead to a flood of gynaecologists and a trickle of obstetricians; whether we will see a flood of midwifery researchers and teachers, and a dearth of hands-on midwives. Both in Australia and New Zealand, with different models of maternity care, the risks and stresses associated with working in an emotionally charged area of health care will continue to take their toll on the health care workforce. It is probably too optimistic to hope for an abatement in the culture of blame and litigation pervading the healthcare sector, but as the roles of disease processes and health care management become more clear in determining outcome during pregnancy, hopefully the negative impact of the medicolegal environment will diminish, encouraging health care workers to continue using their hard earned skills to support families through the joys and tribulations of childbirth[7].

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