The clock keeps ticking, the builders keep building

Yet key patient safety questions remain unanswered...

Associate Professor Paul McGurgan
AMA (WA) Obstetrics & Gynaecology Representative

Construction is now well underway on the major expansion of Osborne Park Hospital (OPH), a central component of the State Government's $1.8 billion New Women and Babies Hospital Project. The development promises significant investment in women's and newborn services in Perth's northern suburbs, including expanded inpatient facilities, a family birth centre, and a dedicated mother-baby mental health unit.

However, infrastructure alone does not guarantee safe, high-quality care. Following consultation with members – senior clinicians in obstetrics and gynaecology, paediatrics and neonatology – the AMA (WA) wrote to the Minister for Health on 23 March 2026 to outline a series of patient safety, governance and service design concerns. The AMA (WA) awaits the Government's response, even as physical works continue on site.

At the heart of the AMA (WA)'s concerns is the proposed clinical model for an expanded OPH service. As clinicians have consistently highlighted, OPH does not have an emergency department and lacks co-located adult medical and surgical specialties – capabilities that are typically fundamental to contemporary obstetric and gynaecology services.

In the spirit of constructive engagement, the AMA (WA) requested four areas of clarification from Government.

1. The clinical safety rationale for progressing expanded obstetric and gynaecology services at OPH without an emergency department, and with limited acute specialty co-location. This includes how time critical, non-obstetric or non-gynaecological conditions, such as cardiac or neurological emergencies, will be managed in a complex patient cohort.
2. Confirmation of the planned clinical escalation pathways for women in the northern suburbs, including retrieval and transfer arrangements, expected time-to-definitive-care, and the workforce assumptions underpinning these processes. This is particularly relevant for acute gynaecological presentations, intra-operative complications, and post-discharge emergencies.
3. Clear advice on governance arrangements, including who owns and accepts patient-safety risks, how these risks are being assessed, and what mitigation strategies will be implemented, and when. AMA (WA) members have expressed concern that splitting services across multiple health service providers (North Metropolitan, South Metropolitan and Child and Adolescent Health Services) will likely create fragmentation and ambiguity in accountability.
4. Clarity on why clinician-proposed co-located options – particularly at the QEII Medical Centre – have not progressed, and whether these proposals, or a tri-located model aligned with international best practice, could be revisited.

These requests reflect a consistent message from frontline clinicians: that safe maternity care depends not only on facilities, but on integrated service design, timely access to critical care, and robust governance. Contemporary models internationally emphasise co-location of obstetric, neonatal, emergency and adult specialty services to manage the unpredictable nature of maternal and newborn care.

The AMA (WA) has been clear that it supports an expanded role for OPH within the broader system. Additional maternity capacity in the northern suburbs is both necessary and welcome. But expansion must be matched by appropriate clinical capability, sustainable staffing, and clear lines of accountability.

As the letter concluded, the AMA (WA) and its members remain committed to working collaboratively with Government and the Department of Health. The goal is shared: to ensure Western Australian women and babies receive safe, high-quality care, supported by clinically appropriate infrastructure and service design.

With construction progressing, the need for transparency and engagement becomes more, not less, urgent. Addressing these questions now, before services come online, offers the best opportunity to mitigate risk, build workforce confidence, and ensure the expanded OPH service delivers on its promise.

Put simply, while the builders keep on building, clinicians are still waiting for answers. ■

> **"The goal is shared: to ensure Western Australian women and babies receive safe, high-quality care, supported by clinically appropriate infrastructure and service design.**

cpd home EA

Birth plans, intrapartum care and consent... Proceed with caution!

Associate Professor Paul McGurgan
AMA (WA) Obstetrics & Gynaecology Representative

Source: David Falconer; US National Archives and Records Administration – Public Domain.

Intra-partum care has always been a complex area regarding consent. Most patients have high expectations regarding their birth experience but are frequently in pain and/or physically exhausted when in labour, and interventions may be required.

Intra-partum procedures are usually time-critical, with risk of poor outcomes for both mother and baby; in the public system, these high-stakes interventions are often performed by health professionals the patient has never met previously. It is a perfect recipe for miscommunication, dissatisfaction, distrust... and litigation.[1]

The stakes are now even higher following the Supreme Court of Victoria's landmark decision in *Gawthrop v Bendigo Health*.[2]

The case involved Larissa Gawthrop, a first-time mum who understandably stated she *'want[ed] to have choices about what happens to myself and my body'* when pregnant. Larissa initially considered a home birth, but later decided on a hospital setting as she recognised that *'birth can sometimes not go so well';* she enrolled in Bendigo Health's midwifery-caseload service known as Mamta.[2]

Larissa prepared a four-page birth plan during her pregnancy, in which she and her partner Jono stated their birth preferences. As this was a significant focus in the trial, it is useful to document some of the content.

Our intention is to have a physiological birth ... although we understand in the event of special circumstances our plans may change and we will rely on your guidance and expertise, remaining committed to our preferences where possible.

"The case illustrated some healthcare providers' predilection to rigidly follow guidelines/ protocols and their senior's advice, along with a 'box-ticking' mentality and focus on hospital funding.

The welfare of our baby is most important to us. We will absolutely accept and discuss advice if urgent or emergency situations arise.

My plan includes important information regarding informed legal consent. We look forward to participating in fully informed discussions, which include the benefits, risks, alternatives and supporting research.

I DECLINE ALL vaginal examinations unless there is an urgent medical reason to do so. Informed verbal consent MUST be given from myself prior. If an urgent medical reason indicates an examination, I DO NOT wish to be informed of my dilation.[2]

Following her care during labour, Larissa sued for assault, battery and negligence in the Supreme Court of Victoria.

The Court ruled in her favour, awarding Larissa over $275,000 in damages. The Judge found that:

- performing a vaginal examination without valid consent amounted to assault and battery; and
- the hospital's overall care was negligent.

The case is important for health professionals to be aware of, as it provides contemporary perspectives on how the Australian legal system views informed consent, patient-generated 'Ulysses-type' contracts, care provision and health service protocols/guidelines.

Informed consent

The trial focused on Bendigo Health's Informed Consent Policy which, like most contemporary jurisdictions, rests on the four pillars of capacity, informed decision-making, voluntariness and timeliness. **The key issue was coercion.** Despite Larissa repeatedly refusing a vaginal examination by the assessment unit midwife, she and her partner were informed she would not be admitted, access the care of the Mamta team, or have adequate analgesia provided unless she complied with a vaginal examination.

It is notable that the Judge found that later intra-partum care provided (vacuum-assisted birth and episiotomy) were adequately consented to. So, caution should be taken in circumstances when patients initially refuse consent; any

further interaction with healthcare providers should ensure there is no element of coercion. The case also reinforced the concept that each intimate examination/procedure is a separate consent event.

'Ulysses-type' contracts in healthcare

Patient-authored care preference documents, often termed 'Ulysses-type' contracts,[3] present distinct clinical challenges. Patients may outline care goals or preferences that are clinically difficult to achieve or inadvertently unsafe. Furthermore, a systemic lack of effective cross-team communication often prevents multidisciplinary providers from being aware of, or accessing, these documents during subsequent care.

In the Gawthorp case, the legal status of birth plans was not detailed, but it's clear the Court expected such patient-led documents to be treated as clinically and legally important. Specifically, Bendigo Health was found to be negligent as it failed to:

- respect the birth plan;
- provide adequate information and alternatives to the plaintiff; and
- conditioned the provision of care options on Ms Gawthrop's consent to have a vaginal examination.

The trial evidence indicated that Larissa's birth plan was discussed with her midwives antenatally, and that she was *'likely to have been reassured that her birth plan and specific preferences in respect of vaginal examinations was "achievable".'*

Her sole obstetric consultation was initiated due to Larissa's request for a physiological third stage; she subsequently decided to opt for active management when informed about the evidence for increased risk of postpartum haemorrhage. In hindsight, this clinic visit was a missed opportunity for the obstetric team to discuss and address other aspects of Larissa's birth plan.

'Box-ticking' care provision and health service protocols/guidelines

The Judge found that Bendigo Health breached the standard of care defined by its own policies. The trial also highlighted inconsistencies between local and state protocols and guidelines.

The case illustrated some healthcare providers' predilection to rigidly follow guidelines/protocols and their senior's advice, along with a 'box-ticking' mentality and focus on hospital funding. These types of behaviours were first described by Milgram as a result of his experiments on human obedience as being 'agentic'; individuals can shift their personal responsibility on to some higher authority, despite awareness that their actions may cause harm to others.[4]

Closing comments

The Gawthrop case has wide implications for all Australian healthcare and health service providers. In maternity care, women's preferences for care must be the central focus for all their healthcare providers.

Women with birth plans that may be difficult to achieve, or inadvertently increase risk to them or their baby, deserve timely access to healthcare providers who can provide them with non-coercive, evidence-based information on the advantages and disadvantages associated with their choices, and what implications these may have on their own health and wellbeing and that of their children.

In modern medicine, the treating doctor's duty to inform a patient is considered to be non-delegable.[5] In Australia, up to 58% of first-time mums require obstetric assistance via instrumental or caesarean birth.[6]

Hence, I believe obstetric care providers and their health services need to ask: *Why do we continue to delegate antenatal education and important birth plan discussions almost entirely to our midwifery colleagues?* ■

"The Gawthrop case has wide implications for all Australian healthcare and health service providers. In maternity care, women's preferences for care must be the central focus for all their healthcare providers.

References available on request.