

## LETTER TO THE EDITOR

# Comment on: Patterns of transfer in labour and birth in rural New Zealand

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## Dear Editor

I read with interest the article by Patterson et al. regarding delivery in rural facilities<sup>1</sup>. Of the women who began labor in rural facilities where midwives managed labor, 16.6% were transferred to a secondary or tertiary center, with a mean transfer time of 78 min. I have three concerns.

First, I wonder how many women actually remained in the rural community throughout pregnancy. Patterson et al. investigated women after labor initiation and showed that 83% had remained there. However, some women may have been transferred before labor following antepartum triage, thus the women remaining in the community throughout pregnancy may be much fewer. A randomized controlled study showed that of low-risk pregnant women, only 46% delivered their babies solely under midwives' care: 34% and 16% were transferred to an obstetrics unit before and after labor initiation, respectively<sup>2</sup>. Thus, even for a low-risk

pregnancy, 16% of women required obstetric care after the initiation of labor. This percentage corresponds with the transfer rate of Patterson et al. (16.6%), indicating that many who began labor in rural facilities were low-risk pregnant women. This suggests that appropriate antepartum triage was performed in this area.

Second, I wonder if it is justifiable for midwives to solely deliver pregnant women in a remote area, even after appropriate antepartum triage. While I agree with Patterson et al. that 'birthing locally is important', this is only paramount when mothers' and neonates' safety is guaranteed. In Patterson et al.'s study, maternal transport required a mean duration of 78 min<sup>1</sup>. Some mothers were transferred due to fetal distress, perinatal trauma or hypertension, conditions that often require acute treatment. For example, delivery within 17 min or 20 min is required in fetal distress due to uterine rupture<sup>3</sup> or placental abruption<sup>4</sup>, respectively, to ensure the baby's survival. Further, to reduce maternal or fetal jeopardy, the earlier the delivery, the better



the outcome. And while appropriate antepartum triage detects high-risk pregnancy and thus reduces the group of rural-remaining pregnant women to those of low risk, 'low risk' does not mean 'no risk'. While fetal distress, trauma, or hypertension may be predictable in some cases, they may also arise acutely in 'low risk' pregnancy.

Third, I would like to address an ethical issue. Naturally, care providers will inform pregnant women of the merits and drawbacks of birthing in a rural facility. Women who consider that the merits outweigh the drawbacks will choose to remain in the rural facility. However, we must not forget the other 'silent patients': the fetus and neonate. Care providers should be their advocate.

In my three-decades of obstetrical practice, in both rural clinics and tertiary centers, I have noted that pregnant women tend to underestimate the dangerous aspects of birth, despite being sufficiently informed. A 'normal' delivery is confirmed so only after delivery. I agree with Patterson et al.'s comment that many rural women hope to deliver in their own community. However, since grave disorders can occur even in low-risk pregnancy, and since we cannot obtain informed consent from the fetus, I believe that rural facilities should only conduct obstetric deliveries when an emergency transfer system is available. Furthermore, we can anticipate the most dangerous time, the due date.

As for the outcome of those 16.6% of women and babies who were transferred, my concern would be whether maternal or neonatal mortality and/or morbidity occurred.

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