

Maternity Services Model of Care

Service: West Moreton Hospital and Health Service

Division: Women, Children and Family

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Prepared by: Alison Caddick - Midwifery Manager of Birth Suite

Contributors: Dr Brian McCully – Director of Obstetrics and Gynaecology

Approved by:

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For further information, please contact the Nursing/Midwifery Director for Women, Children and Family Services, West Moreton Hospital and Health Service, PO Box 73, IPSWICH QLD 4305. Telephone 3810 1672.

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Table of Contents

Model of Care Overview	4
1. Introduction	5
2. Purpose	6
3. Principles of Collaboration	6
4. Implementation Guidance	7
5. The levels of Consultation and Referral	8
Flow Chart.....	10
6. Roles and Responsibilities	11
7. Interdisciplinary Communication	11
8. Leadership Framework	12
9. Scope of Practice	13
10. Patient Autonomy	13
11. Risks	14
12. Supporting Documents	15
13. APPENDIX 1	
Summary of the ACM Codes.....	16
APPENDIX 2	
Case Law Summary.....	18

Overview

Maternity Services at Ipswich hospital promotes a culture of safety, accountability and inclusion.

The Maternity Services Model of Care helps provide the best possible care for women during pregnancy, labour and birth and the postpartum period. It strives to ensure that the needs of women, their families and the community are met now and in the future. *The National Midwifery Guidelines for Consultation & Referral*, published by the Australian College of Midwives (The ACM Guidelines) in 2013, is the basis for this model.

The ACM guidelines provide information to assist midwives to integrate evidence with experience (clinical judgement) in providing midwifery care; and to assist midwives in their discussions with women regarding the suitability of different maternity care options. The Guidelines are not designed to be prescriptive and should not be interpreted and/or used as a substitute for an individual's decision-making and judgement in situations where care has been negotiated within the context of informed decision-making by a woman. Incorporating the ACM Guidelines into practice as the basis for the maternity services model of care provides an evidence based framework for collaboration between midwives and doctors in the care of individual women. Identification of risk, and pathways for consultation, referral and transfer are clearly defined enabling health professionals to provide safe, standardised, woman centred care. State-wide Guidelines and West Moreton hospital and Health Service (WMHHS) work place instructions will continue to guide staff in the clinical management of pregnancy, labour, birth and the postpartum period.

This Model of Care for Maternity Services:

- Acknowledges the *National Midwifery Guidelines for Consultation & Referral, 3rd edition Issue 2, 2013* published by the Australian College of Midwives (ACM) and their endorsement by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in 2015.
- Acknowledges the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2015, '*Maternal suitability for models of care, and indications for referral within and between models of care and Standards of maternity care in Australia and New Zealand, 2016*'
- Promotes a collaborative model of service delivery where midwives, medical officers, GP's and specialist obstetricians work together as a multidisciplinary team to provide care that is safe, evidenced based and patient centred.
- Recognises birth as a normal physiological event for many women and families, and identifies risks of pregnancy, labour and birth.
- Is woman-centred and ensures the woman can make informed choices about all elements of care, but also recognises the responsibility the woman has for decisions she makes outside the clinician's recommendations.
- Clearly identifies roles and accountabilities of team members and endorses a just culture of accountability, safety and respect.
- Acknowledges that Queensland does not offer a publicly funded homebirth program and therefore WMHHS maternity services cannot support home birth as an appropriate place for birth.

1. Introduction

The National Maternity Plan (2011) sets out the Federal Government's vision for maternity services that "Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live".

Woman centred care is widely recognised as a core dimension of a quality modern health service. Fundamental to informed decision-making is a two-way dialogue between patients and their health practitioners about the benefits, risks and alternatives of treatment, considering the patient's personal circumstances, risk factors, beliefs and priorities. A well-informed patient can actively participate in the decision-making process about their care, and better understand the likely or potential outcomes of their treatment. Informed decision-making also provides an additional layer of vigilance and protection against errors which may result in adverse outcomes. Performed well, the informed decision-making process builds trust, prevents harm and reduces surprise and distress if complications or adverse events do occur.

The care that a woman receives during pregnancy, labour and birth and the postpartum period has the potential to affect the woman herself, both physically and emotionally, and the health of her baby in the short and longer term. Good communication, support, and compassion from staff, as well as having her wishes respected, can help her feel in control of what is happening and help make birth a positive experience for the woman and her birth companion(s).

In this setting, healthcare providers should ensure that there is a culture of respect for each woman as an individual undergoing an important and emotionally intense life experience. The woman should be in control, listened to, and cared for with compassion. Appropriate informed consent should be sought. Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth. Fully informed decision making is the key to respectful safe maternity care, and minimises the incidence of birth trauma reported by women.

The ACM Guidelines are used throughout Australia by midwives and health services providers in both private and public sectors as an effective guide to safe collaborative maternity care. The midwife is responsible for constantly assessing, determining and documenting maternal, fetal and neonatal wellbeing. In situations where a problem presents during the care of a woman or her baby, the midwife is guided in making evidence based decisions, and consultation and referral processes, via professional, and hospital policies and guidelines. Women and their babies benefit from a model of care which promotes and encourages close mutual collaboration between the primary care midwife and the obstetric and paediatric teams.

Incentives highlighted in the 2013 Queensland Government's Blueprint for better healthcare in Queensland emphasized a commitment to closer working relationships between GPs and the hospital system by developing robust clinical pathways between primary, secondary and tertiary care. GP's within the WMHHS area and referring to Ipswich Hospital for maternity care will continue to utilise the RANZCOG '*Maternal suitability for models of care, and indications for referral within and between models of care*' document (RANZCOG, 2015)

2. Purpose

Maternity Services at WMHHS face a rapid growth in demand of service delivery in the coming years. This is commensurate with population trends but includes as well, an expectation from the community to support varied models of birthing care. Managing these demands safely for both community and care givers, requires a clearly articulated model of care for maternity services.

The implementation of the ACM Guidelines provides a standard for:

- The categorisation of a woman's health condition at the time of presentation.
- The model or complexity of care appropriate for that presentation with an acknowledgment that when no risk is identified, midwifery and/or shared care is the recommended model of care, i.e. there is no indication for consultation or referral.
- Factors or conditions that may change or escalate the degree of any risk associated with that presentation with an acknowledgement that when risk is identified, care givers must follow the process of collaboration.
- The processes of collaboration and communication called into play to assist in the transition of care if required, depending on the risks identified, and include:
 - None.
 - Discussion
 - Consultation.
 - Referral.

3. Principles of collaboration

In maternity care, collaboration is a dynamic process of respectful communication, trust and compliance with standardised pathways that allow health professionals to provide safe, effective woman-centred care. Collaborating professionals trust and acknowledge each other, use careful and sensitive communication, and follow agreed processes for interdisciplinary shared practice.

A commitment to shared principles of collaboration provides practitioners with a framework for individual clinical practice that can enable best-practice maternity care.

These principles include:

- Maximising a woman's continuity of care throughout her maternity episode and enabling a woman to be an active participant in their care, and to make informed decisions by ensuring they receive information about all their options.
- When risk is identified, early consultation and active involvement of the obstetric team is to be recommended.
- A shared understanding that collaboration is a dynamic process for facilitating communication and care pathways (including consultation, referral and transfer) that enable health professionals to provide safe, high quality, woman-centred care with good, well supported and clear documentation.
- Collaborating professionals trusting, respecting and valuing each other's roles, using careful and sensitive communication, providing support to each other in their work and following agreed processes for collaboration.
- That the roles and responsibilities of everyone involved in the woman's care are clearly defined, particularly for the person the woman considers to be her primary maternity carer and decision maker.
- Each practitioner being responsible and accountable for the care they provide.
- When a woman chooses an option of care which is non-standard or not in line with state-wide guidelines and WMHHS workplace instructions, all the options need to be discussed with the woman, a collaborative approach with well documented discussion is essential. The WMHHS legal team and referral tertiary obstetric specialist clinicians may be consulted as part of this collaboration.

4. Implementation Guidance

The model of care recognises that women will make the choice about their care and birthing choices in most circumstances.

- It is incumbent upon all care givers to provide balanced and contemporary clinical advice to ensure that informed decisions are made.
- Caregivers are expected to adhere to the recognised consultation and referral guidelines developed by the Australian College of Midwives (ACM) and to have processes and relationships in place to demonstrate compliance with these guidelines.
- Clearly articulated and documented plans of collaboration and escalation are integral to provision of safe, individualised high-quality care leading to positive outcomes for mothers and babies.
- A written record of these processes is essential to verify adherence to the framework in the event of any adverse outcome and /or subsequent legal action or professional investigation or in situations where the woman chooses not to follow clinical advice about the need for interventions or transfer where she has been informed of the risks of adverse outcomes.
- Should a condition be identified that is not included in the ACM Guidelines, a consultation with a specialist obstetrician should occur and a plan developed, agreed and documented.

5. The Levels of Consultation and Referral

Where there are no known risks or complex needs, midwives are responsible and accountable for providing all primary care needs of a woman and her baby. Consultation and referral with other health professionals is required in cases when complexities and variances arise as per listed in the ACM Guidelines.

When a variance from normal is identified during a woman's care, it is recommended the midwife or GP (in a shared care model) undertake one or more of three steps.

- A. Discuss the situation with a colleague and/or with a medical practitioner, and/or another health care provider; and/or
- B. Consult with a medical practitioner or other health care provider; and/or
- C. Refer a woman or her infant to a medical practitioner for Secondary or Tertiary care

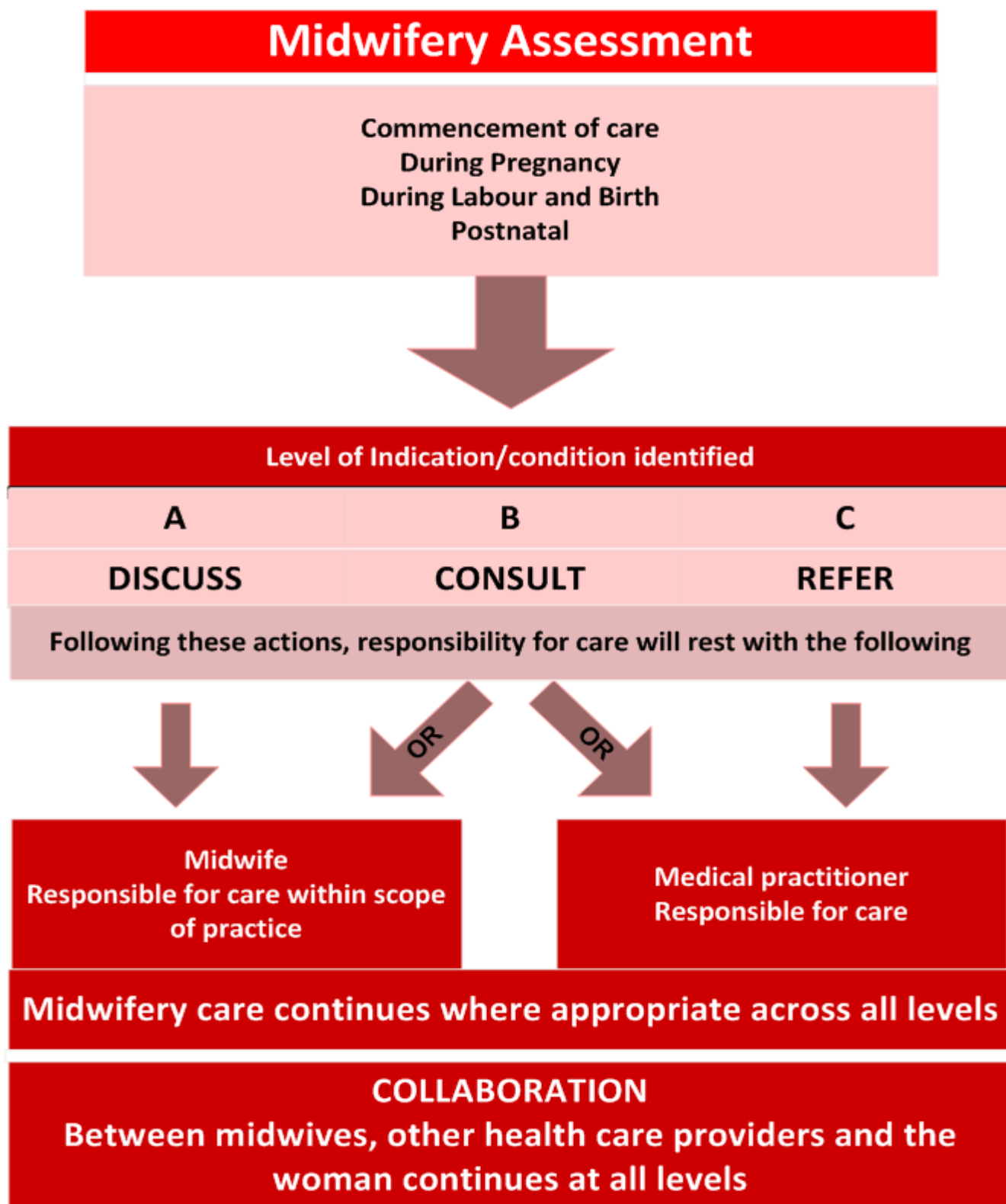
In general, the following principles apply:

- A consultation refers to the situation where a Midwife (or GP in a shared care model) recommends the woman consult a specialist obstetrician; or where the woman requests another opinion.
- The individual situation of the pregnant woman is evaluated and agreements are made about the responsibility for maternity care, based on the ACM Guidelines.
- It is the Midwife's (or GP in a shared care model) responsibility to initiate a consultation and to clearly communicate to the appropriate medical practitioner that they are seeking a consultation.
- The consultation involves addressing the issue that led to the request for consultation, a 'face to face' assessment, and the prompt communication of the findings and recommendations to the woman and the requesting professional.
- Where a consultation occurs, the decision regarding ongoing clinical roles and responsibilities should involve a discussion between the appropriate medical practitioner or health care provider, the Midwife (or GP in a shared care model) and the woman concerned. This should include discussion about any need for, and timing of, any further obstetric review.
- The woman may choose to consent to or decline the consultation. Seeking a consultation does not transfer responsibility for care. If the medical practitioner or health care provider recommends a change to the responsibility of care, this must be clearly communicated to the midwife and the woman involved and clearly documented in the pregnancy health record and hospital medical records.
- The midwife or medical practitioner will not automatically assume responsibility for ongoing maternity care. Responsibility will depend on the clinical situation and the wishes and needs of the individual woman. After consultation with an appropriate medical practitioner, it should be clearly established whether primary responsibility for maternity care:
 1. Continues with the midwife or GP (primary care), or
 2. Is referred to the obstetric service medical practitioner (secondary or tertiary care)

- The appropriate medical practitioner may be involved in, and responsible for the woman's ongoing care or for a discrete area of care, with the Midwife (or GP in a shared care model) maintaining overall responsibility within their scope of practice.
- Where urgency, distance or climatic conditions make a 'face to face' consultation between a woman and an appropriate medical practitioner impossible, the Midwife (or GP in a shared care model) must seek advice from the appropriate medical practitioner by phone or telehealth facilities. The Midwife (or GP in a shared care model) should document this request for advice in their records and the Pregnancy Health Record, and discuss with the woman the advice received.
- Areas of discussion and involvement in maternity care must be clearly agreed upon and clearly documented in the woman's medical record.
- Seeking a consultation does not necessarily obligate a transfer of primary responsibility for care.

Emergency management

In an emergency, clinical responsibility is immediately transferred to the most appropriate practitioner available. The clinical roles and responsibilities of the attending practitioners are dictated by the needs of the mother and baby and the skills and expertise of the practitioners available. In an emergency a health care provider cannot refuse to attend and treat a woman or infant.



See Appendix 1 for a summary of the levels of consultation & referral and refer to National Midwifery Guidelines for Consultation and Referral for specific indications for discussion, consultation and/or referral of care.

6. Roles and responsibilities

Caregivers employed by WMHHS are regulated health practitioners and have a responsibility to work within their scope of practice. This is defined individually by accreditation with professional and organisational standards in accordance with relevant State, Territory and Commonwealth legislation. In addition, all WMHHS employees providing maternity care are expected to be compliant with the Maternity Services Model of Care.

This also includes:

- GP's entering into a shared care arrangement with WMHHS (GP Shared Care Alignment Guidelines 2017 (version 3); and
- Privately Practising Eligible Midwives who are credentialed and have a collaborative arrangement with WMHHS.

The WMHHS will be responsible for:

- Divisional ownership of the project.
- Identifiable leadership and support of the project including timely decision making for key actions and recommendations arising from the project.
- Audit and quality assurance activities to monitor compliance, risk and change strategies to exist and sustain the project beyond the recommendations for implementation.

7. Interdisciplinary Communication

Communication is an important aspect of collaborative maternity care. Each professional is responsible for sharing and documenting accurate and appropriate information that may affect decision-making. Any communication process must include the woman and with her permission, her relevant support persons. It is best practice to have processes that encourage early and regular communication between collaborating health professionals about the care and clinical circumstances of all women receiving maternity care.

Where a midwife is responsible for primary midwifery care, this must be provided as part of a broader collaborative arrangement. While it is recognised that the woman is responsible for choosing her model of care, it is the responsibility of the midwife to ensure that the woman is fully informed and encouraged to involve other care provider(s) when indicated. The midwife must ensure that the woman is also informed, as appropriate, about the risks any failure to involve, or to delay the involvement of other care providers, pose. When relevant, these risks must be explicitly discussed and documented, relying on acceptable clinical practice and consideration of individual circumstances. Similarly, medical/obstetric staff must ensure that the woman is informed of the risks and benefits of any recommended interventions in care, and all options available to them. The discussions must be comprehensively documented.

There is a range of clinical circumstances that should trigger a midwife to initiate collaborative communication. Midwives who identify clinical indicator(s) that are coded “B” and above, by the ACM National Midwifery Guidelines for Consultation and Referral (2013) should seek early and if necessary, ongoing communication and collaboration with medical colleagues. This will include open, informed discussion with the woman to ensure that she and her support persons remain centred and fully informed. This consultative process will include an understanding of:

- When the midwife should consult, refer or transfer the care of the woman and baby to appropriate medical practitioner(s);
- To whom the woman or baby would be referred; and
- Where that medical care would likely be provided.

The outcome of such communication in terms of recommendations for ongoing care will vary depending on the clinical implications, local availability of different services, the discussion between the midwife and the obstetrician and the consent of the woman. Any communication may result in the simple exchange of information, advice from the obstetrician to the midwife about management, referral of the woman for a consultation with the obstetrician, or, a recommendation for transfer of the primary maternity care coordinator role to the obstetrician.

8. Leadership Framework:

- The Divisional Director has end point accountability for Women, Children & Family Services and ensures deliverables are achieved in accordance with the Service Agreement.
- Accountable to the Divisional Director, the Director of Obstetrics will have responsibility to provide a safe and effective Maternity Service.
- Accountable to the Divisional Director, the Director of Paediatrics will have responsibility to provide a safe and effective Neonatal/Paediatric Service.
- The Nursing/Midwifery Director manages clinical practice standards and ensures the delivery of high quality patient care.
- The admitting obstetric consultant carries ultimate responsibility for clinical decision making in the antenatal and postpartum period. In the absence of the admitting consultant, responsibility is delegated to another team consultant or the rostered birth suite consultant.
- The rostered birth suite obstetric consultant will be the defined clinical leader of birth suite who carries ultimate responsibility for clinical decisions within the birth setting.
- After-hours ultimate responsibility for clinical decisions across the whole of maternity services lies with the rostered-on call obstetric consultant.

This is contingent on individual care-givers who must always:

- Comply with the standards and requirements of their regulated profession.
- Work within the responsibilities of their accredited scope of practice.

- Respect women's right to autonomy and informed decision making as per Queensland Health Guide to Informed Decision Making in Health Care.
- Continue to reassess evolving clinical situations and continue to explicitly communicate to the woman how these changing circumstances alter risk to themselves or the baby.
- Escalate concerns as necessary.

9. Scope of practice:

Scope of practice is defined within a contract agreement of clinical service for each individual caregiver based on credentialed experience, accreditation and recognised role responsibilities. Within the WMHHS Maternity Services Model of Care, all midwives and doctors are recognised as responsible and accountable professionals who work in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period. Being accountable not only means being responsible for something but also ultimately being answerable for your actions. Each professional take responsibility for their own scope of practice and is accountable for their own actions, including escalation of situations beyond their scope of practice.

10. Patient Autonomy:

All competent adults, including pregnant women, have the right to decline recommended 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 the death of a fetus, or in extreme cases the death of a mother.

Australian courts have consistently upheld this right (*Hunter and New England Health Service v A (2009)* and *Brightwater Care Group v Rossiter (2009)*).

There is currently no case law in Australia regarding the refusal of treatment to save an unborn child's life. However, it is likely that if the issue ever arises, the courts will follow the precedent set in the United Kingdom. See Appendix 2 for full case summary

The maternity services model of care recognises that the woman has ultimate responsibility for decision making regarding her health and the health of her baby.

Most pregnant women will make decisions that are in the best interests of their baby/ies. However, women and clinicians may disagree about the best way to protect and promote those interests.

When a woman declines, or expresses an intention to decline, recommended maternity care, care givers are advised to refer to the Queensland Health (Clinical Excellence Division) Guideline "Partnering with women who decline recommended maternity care draft v0.6

Qualified health professionals at WMHHS working within their designated scope of practice are vicariously covered by WMHHS professional indemnity insurance, but always remain accountable for their own

practice. There are exceptions to the indemnity policy and the circumstances of each matter will be assessed on a case by case basis and on its own merits.

11. Risks

WMHHS values the contribution all staff members make to provide high quality care to women and their families. It recognizes that to do so, staff must feel protected and safe within their working environment. By providing a clearly articulated Model of Care, WMHHS provides a platform of certainty for all staff to understand and acknowledge their role expectations and to be confident of the protection that compliance to these organizational standards affords.

12. Supporting Documents

1. Australian College of Midwives (ACM) 2014, *National Midwifery Guidelines for Consultation and Referral, 3rd Edition Issue 2*. Online available at: ACM website
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2015, *Suitability Criteria for Models of Care and Indications for Referral Within and Between Models of Care*. Online available at: RANZCOG website
3. Queensland Government. Guide to informed decision making in health care. 2nd ed: Queensland Health;2017
4. Queensland Health (Clinical Excellence Division) Guideline 'Partnering with women who decline recommended maternity care' draftv0.6
5. A Just Culture Policy (WMHHS2015191)
6. www.internationalmidwives.org
7. Hunter and New England Area Health Service v A (2009) 74 NSWLR 88.
8. Brightwater Care Group v Rossiter (2009) WASC 229.

Appendix 1

Summary of the ACM Codes.

Code	Description	Care provider with primary responsibility
A/A*	DISCUSS A discussion will be initiated with another health care provider to plan care.	Midwife and/or medical practitioner or other health care provider.
B	CONSULT Evaluation involving both primary and secondary care needs. The individual situation of the woman will be evaluated and agreements will be made about the responsibility for maternity care.	Midwife and/or medical practitioner or other health care provider
C	REFER This is a situation requiring medical care at a secondary or tertiary level for as long as the situation exists. The request for referral will be made in writing. Alterations in care will be communicated in writing to the midwife.	Medical practitioner (for secondary or tertiary care). Where appropriate the midwife continues to provide midwifery care.

A or A*. DISCUSS

A - Discussion will be initiated with a colleague (midwife), and/or with a medical practitioner, and/or another health care provider to plan care.

A* - is the category for midwives endorsed to prescribe scheduled medicines and order diagnostic and screening tests.

- The Midwife (or GP in a shared care model) will provide clinical care and, if necessary, call upon a qualified health professional with the necessary skills and experience (as reasonably expected) to assist them in the provision of care.
- The Midwife (or GP in a shared care model) will recommend to the woman that consultation with a suitably qualified health professional is warranted if her pregnancy, labour, birth or postnatal period (or the baby) may be affected by a suspected or recognised condition.
- It is the Midwife's (or GP in a shared care model) responsibility to initiate a discussion with, or provide information to another medical practitioner, with whom the care is shared, in order to plan and provide care appropriately.
- The specialist obstetrician/health care professional will not routinely assume responsibility for ongoing care; they will work collaboratively with the Midwife (or GP in a shared care model) to safely meet the wishes of the individual woman.
- Any exchange of information or advice must be clearly documented and agreed upon by the people involved in the discussion.

B. CONSULT

A consultation refers to formal communication with an appropriate medical practitioner (Ipswich Hospital obstetric team - PHO, Registrar, Consultant), and/or another health care provider in circumstances where a change or risk or ongoing patient safety is identified. A midwife may discuss the clinical circumstances with an appropriate health professional to select or confirm a particular course(s) of action. The midwife may

recommend that the woman herself consult with the selected health professional. Depending on the outcome of the consultation, recommendations would include that the midwife continue or not continue in his/her role as the primary care provider and decision maker. That is, consultation with an obstetrician does not necessarily mean that the obstetrician will become the primary carer and decision maker.

The nature of the recommendation will depend on the clinical circumstances and regional issues, including resources and site and carer aspects of service provision. The obstetrician and the midwife, in consultation with the woman, may recommend:

- That the midwife continues as the primary carer, with or without some recommendations for future management.
- That the midwife and obstetrician enter into a shared-care arrangement so that ongoing care is provided jointly by both the midwife and obstetrician.
- That the obstetrician becomes the primary carer, while recognising that the midwife may continue to have an important role in even the highest risk pregnancy. It is possible that care co-ordination may be transferred back to the midwife at a later stage in pregnancy, labour or the post-partum period.

C. REFER/TRANSFER

This is a situation requiring medical care at a secondary or tertiary level for as long as the situation exists.

The request for referral may be face to face or be made in writing.

- When maternity care is referred (either permanently or temporarily) from the midwife (or GP) to an appropriate medical practitioner, that medical practitioner, in consultation with the woman, midwife or GP, assumes all responsibility for maternity care (secondary or tertiary). The woman must provide informed consent prior to a transfer.
- The obstetrician (or other medical specialist) will assume ongoing clinical responsibility and the role of the midwife (or GP) will be agreed between the specialist, the midwife and the woman. This will include a discussion about the appropriate timing of a transfer of clinical responsibility back to the midwife (or GP) when the condition(s) permit.
- When maternity care is referred to a medical practitioner, the midwife may continue to provide midwifery care within the midwife's scope of practice, in collaboration with the medical practitioner.
- Areas of discussion, responsibility and involvement should be agreed upon and clearly documented and communicated to the woman.

Regardless of the nature or level of discussion, consultation or referral, communication between providers about changes to management plans should include the woman involved, and should be clearly documented in the woman's medical record and communicated to all people involved.

Appendix 2

Case Law Summary:

There is currently no case law in Australia regarding the refusal of treatment to save an unborn child's life. However, it is likely that if the issue ever arises, the courts will follow the precedent set in the United Kingdom. In that country, there have been several cases of mothers refusing to undergo caesarean sections that were necessary to save their unborn child's life. The law has always focused on the mother's right to self-determination, despite the moral implications, even if this results in harm to the unborn child. Despite the UK's demonstrated consistent approach to the issue, this is in stark contrast to the position held in the United States, where in one case a mother's wishes were overridden and a caesarean section was ordered to be performed because the court had decided that this was in the unborn child's best interests. It should be noted, however, that this case has not been followed by all US courts. However, it is both interesting and important to note that, in the UK, a number of these types of cases have been resolved by challenging the capacity of the mother who is refusing the treatment. In these cases, it was found that there was a temporary loss of capacity and the treatment was in the woman's best interest.