Amy Coopes reported on the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Annual Scientific Meeting in Melbourne on 13 – 16 October 2019, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. 
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Women’s health advocates urged to step up efforts in advocacy

A cultural safety workshop kicked off #RANZCOG19 discussions on the wider determinants of health. Image via @ranzcog tweet

Introduction by Croakey: The presidents of leading medical colleges have issued a joint statement calling on the Australian Parliament to maintain the Medevac legislation and the Independent Health Advice Panel (IHAP) process.

They say the Medevac legislation has improved access to appropriate healthcare for refugees and asylum seekers being held offshore, and that “previous delays and failures to transfer ill asylum seekers resulted in preventable suffering”.

One of the signatories is the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), which is planning to step up its advocacy on the wider determinants of health more generally.

Amy Coopes previews some of the RANZCOG conference discussions below, ranging from efforts to reduce stillbirth to the impact of clinicians’ mental health upon the safety and quality of healthcare.
Amy Coopes writes:

As the peak body of experts in Australia and New Zealand for women’s health, it is time for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to speak up on the social and cultural determinants of wellbeing for women, an annual trans-Tasman summit of the specialty will hear in Melbourne this week.

The RANZCOG, the training and accreditation body for specialists in women’s health, should also be a leading voice on systemic issues including gender equity and access to care, its annual scientific meeting will be told.

The mental health of trainees, political pledges on pelvic pain and stillbirth, and women’s reproductive rights following the recent decriminalisation debate in NSW are some of the other headline topics to feature at the meeting.

Themed ‘Stop. Start. Continue’, the meeting will bring together more than 1,000 obstetricians and gynaecologists from the two countries to explore the latest advances in the field, and reflect on future directions for the College, which has been buffeted in recent years by the controversy surrounding use of pelvic mesh.

The mesh issue featured prominently in last year’s program (read our coverage here), and ASM convenor Associate Professor Joanne Said said this year’s theme aimed to take the discussion forward, asking delegates to stop and reflect on their professional practices, think about what needed to continue or cease, and start some difficult conversations.

“Mesh was something that was introduced, and I guess one of the good things was that a degree of ongoing surveillance identified problems,” Said told Croakey ahead of the ASM.

“That’s an obvious example where the recognition of harms made it easy to take that decision to stop, whereas sometimes it’s a lot more subtle than that. There are therapies that we introduce because we think they’re good and we think they’re evidence-based but actually you realise there is not a strong evidence base for them and over time they may not be doing any harm, but they’re not actually doing any good.”

International keynote speaker Dr Ranee Thakar, president of the International Urogynaecological Association and a subspecialist in urogynaecology at London’s Croydon University Hospital, will present on the lessons from mesh as part of a plenary on pelvic pain which will focus on endometriosis, singled out as a new priority area for research by the Federal Government last year.

Tackling stillbirth

Stillbirth will also feature prominently on the program, with a dedicated plenary session timed to coincide with the launch in Canberra by Health Minister Greg Hunt of the Safer Baby Bundle, a suite of eLearning resources to be rolled out nationwide following a $3 million grant from the Medical Research Future Fund.

Six babies are stillborn in Australia every day, a rate significantly higher than comparable countries, and last year’s Senate Inquiry made a suite of recommendations aimed at reducing rates by 20 percent over the next three years, through targeting gaps between evidence and practice.
The Safer Baby Bundle, which was launched in Victoria earlier this year, comprises five main pillars:

- Foetal growth restriction
- Smoking cessation
- Maternal sleeping position
- Foetal movement awareness
- Timing of delivery for women at risk.

The national launch, at Parliament House in Canberra, will be held on International Pregnancy and Infant Loss Remembrance Day, marked annually on October 15.

**Speaking up**

RANZCOG has stepped up its public profile in recent years, and though this was partly necessitated by the mesh issue, President Dr Vijay Roach said it also reflected a growing expectation from its members that the College be more outward-looking, and outspoken on issues affecting women’s health.

“We are the peak body in women’s health in Australia and New Zealand, and therefore we should be at the forefront of advocacy in issues such as gender equity, as well as social and cultural determinants of health,” Roach told Croakey. “We recognise that there is a growing appetite from our members for a voice in social and political issues as well.”

RANZCOG recently spoke out on the Djab Wurrung birthing trees, saying their cultural and spiritual significance meant protecting them had “immediate relevance to our work in women’s health.”

The College has not historically been outspoken on such issues, but Roach said the profile of RANZCOG’s membership was changing, and that trainees and fellows were more engaged and expected the College to be more representative.
“I think that we are an important voice, we represent women’s health – 2,000 Fellows, 2,000 diplomats, 1,000 trainees, two countries – and what we can lend to the discussion is our experience and our knowledge,” said Roach, nominating RANZCOG’s contributions to the recent abortion decriminalisation debate in NSW as a clear example.

“The College had a very important role to play in advocating for women, and in being very clear about what abortion law reform actually meant, because that’s what we do.”

Dr Paddy Moore, who was vocal during the debate, will present on abortion and equity of access at the ASM.

If RANZCOG was serious about improving the health of Aboriginal and Torres Strait Islander and Maori women, Roach said “we also need to be involved in discussions that are relevant to Indigenous people beyond just clinical medicine.”

“Cultural history and experience is a significant determinant of health outcomes, not just in terms of access but also in terms of how the patient experiences their health, and how doctors then respond to those health needs,” he said.

“We often see that there are terrible disparities for people of diverse cultural backgrounds because the system only looks at healthcare through a single cultural lens, and it’s important that we recognise that another person’s cultural lens could have a profound impact on their experience of the system as well as their experience of health and ill health.”

Gender gaps

In his President’s address, Roach plans to make the case for RANZCOG as an advocacy group in all areas that affect the welfare of its patients, and on issues including mental health, domestic and family violence, “recognising that health care outcomes are determined by many, many factors and we have a responsibility to speak about them”.

He will also launch RANZCOG’s Gender Equity and Diversity Working Group report, which lays out a blueprint for improving the College’s record on women in positions of leadership.

RANZCOG was spurred into action following last year’s ASM, when Hobart-based obstetrician Dr Kirsten Connan presented evidence of a startling gender gap in the upper echelons of the College and urged affirmative action.

Roach said the report recognised that there are “systemic issues that preclude women from taking leadership positions, and the College has a role to identify those”. Childcare, travel, timing of meetings or “potential unconscious biases where women do not feel empowered or encouraged to participate equally in the leadership of the College” were just some examples, he said.

Setting the scene for Roach’s address and the gender equity report launch will be a keynote from Professor Lesley Regan, who heads up the Royal College of Obstetricians and Gynaecologists – RANZCOG’s UK equivalent.

Regan is just the second-ever female RCOG president, and the first in sixty-four years. The title of her talk is ‘How We Are Going to Achieve Sustainable Development Goal 5: Gender Equality for All by 2030’.

The session featuring Regan and Roach is titled ‘Starting the Conversation’ and will also have a focus on trainee mental health, with a special presentation from Richmond Tigers legend Merv Keane, who was inducted into the AFL Hall of Fame earlier this year.
Keane shared the story of his daughter, Emily, who died while undertaking O&G training in 2017. Merv’s grief-stricken wife Kaye took her own life a few weeks later.

Emily’s story is now used in workshops with trainees, and Keane started an initiative called Emily’s Gumboots – the title of his talk – at Melbourne’s Royal Women’s Hospital, her former workplace, to raise awareness of health and wellbeing amongst junior doctors.

Emily was renowned for wearing fluorescent gumboots into the hospital theatres, and the junior doctors at the Royal are now gifted a pair of these boots as a reminder to check in with one another and seek help if they are struggling.

Mental health and quality of care

Former RANZCOG President, Dr Steve Robson, will also speak in the session.

Robson wrote a piece about his attempted suicide as a junior doctor for the MJA last year, which went viral after a colleague who had trained with him posted an extraordinary, heartfelt response detailing how anguished those around him had been and the “desperately staged intervention” that had saved his life.

MJA Insight+, which ran both pieces, has described them as some of the most impactful pieces they had ever published, and Robson said the response had been “utterly overwhelming”.

When asked why the two pieces resonated so strongly, Robson said: “I think it said two things. It said that people can feel awful and not disclose it, and people around can know something is going on and not know what to do about it.”

In his talk, Robson will impress upon colleagues that their own mental health and that of their colleagues is not just important at a personal level, it also contributes directly to adverse outcomes and impacted patient care.
He said:

“I go to a lot of morbidity and mortality meetings and there’s a lot of root cause analysis, and people are looking at why things happen, but you almost never hear ‘Actually someone made a really poor decision because their mind was just not on the job that day because they were worried about something, or they weren’t feeling well, or they were depressed’, that never comes out.

But my sense is it probably is an important part, and the data back that up, of providing care.”

Instead of being stigmatised, and subject to the legislated barrier of mandatory reporting, Robson said good mental health should be promoted as just as integral to patient care as hand hygiene and antimicrobial stewardship.

He said:

“We need to take this into account, we need to destigmatise it, and I think the only way that’s going to happen is with strong leadership, people giving personal lived experience.

We have to totally change the paradigm, and I think personally looking at it from a patient outcome perspective might be a key to trying to turn people around.”

Robson and Professor Martin Delatycki – clinical director of the Victorian Clinical Genetics Services – will also present an update on Mackenzie’s Mission, with clinical trial recruiting to begin very early next year. If the trial of 10,000 couples is successful, Robson said the carrier screening program would be rolled out nationally.

“And that’s unique in the world, there’s no other country that has this sort of system,” he said. “This is a population-based paradigm and if it works it’s really going to alter the way that people think about genetics and the family.”

Associate Professor John McBain will deliver the Arthur Wilson Memorial Oration on the changing landscape of fertility management. McBain was instrumental in the development of IVF, both in Australia and globally, and led the charge for equity of access for same-sex couples and single women, successfully suing the Victorian government and, in turn, being counter-sued in the High Court by the Australian Catholic Bishops Council.

Other keynote speakers at #RANZCOG19 include:

• Prof Basky Thilaganathan from London’s St George’s Hospital, on prediction and prevention of pre-eclampsia

• A/Prof Sawsan As-Sanie from the University of Michigan, on pelvic pain

• Prof William Grobman, from Northwestern University, on induction of labour

• Dr Abdul Sultan from Croydon University Hospital on perineal and anal sphincter trauma

• Prof Laura A Magee from King’s College London on hypertension in pregnancy and postpartum

• A/Prof Ryan Hodges, from Monash University, on research to progress new therapies. Hodges, who has pioneered the use of stem cells to treat newborn lung disease, will present the Ella McKnight Memorial Lecture.
Women's health advocates urged to step up efforts in advocacy

#RANZCOG19

From Twitter

Meanwhile, the #RANZCOG19 tweets are already flowing...

RANZCOG - O&G @ranzcog · 18h
All the participants at today’s Cultural Safety Training. Thanks @AIDAAustralia, thanks @SpringShannon, thanks all #ranzcog19 @coopesdelat @CroakeyNews

RANZCOG - O&G @ranzcog · Oct 12
Kicking off the Aboriginal and Torres Strait Islander Health in Clinical Practice Training Workshop at #ranzcog19 with @AIDAAustralia
You can track Croakey's coverage of the conference here.

Women's health advocates urged to step up efforts in advocacy

#RANZCOG19
Women’s health advocates urged to step up efforts in advocacy

#RANZCOG19
Let’s talk about sex. More often, and as an important part of healthcare

Amy Coopes writes:

Sex is an integral part of wellbeing and should be normalised in discussions about patient health, a summit of Australian and New Zealand obstetricians and gynaecologists heard in a talk where they were urged to continue being curious about sexuality.

Some 1,300 women’s health specialists from across the two countries converged on Melbourne for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ annual scientific meeting, which spotlights the latest advances and controversies in the field.

It was standing room only for Melbourne-based psychosexologist Chantelle Otten’s session on sexuality and sexual dysfunction, where she presented some of the most common problems and questions that crossed her threshold, and reflected on barriers to effective sexual health discussions for healthcare workers.

“I work with the biggest sexual organ, which is the brain,” said Otten, who qualified through the European Society of Sexual Medicine after studies in psychology, science and medicine.

Though sexual therapy was something sought by and relevant to basically anyone and everyone, Otten said her biggest demographic was young people aged 20-40, a group who were trying to get pregnant or facing sexual problems to do with antidepressant or oral contraceptive pill use.
Common questions and presentations

Patients could present for a huge range of issues, but there were some very common questions that she said came up time and time again, with many in the room nodding their agreement as she went through them. These included mismatched desires, discomfort and dysmorphia, and intimacy issues.

"When sex is good, it’s 10 percent of the relationship," said Otten. “But when sex is bad, it’s 80-90 percent of the relationship.”
Addressing concerns

With an average of just one hour devoted to sexuality in medical school, Otten said it was an area that many doctors did not feel comfortable delving into with their patients, and there were a lot of other contributing factors, including a perception by medical professionals that it was not part of their role, time constraints, embarrassment or a concern that it was invasive, particularly with some patient groups.

“I think at the end of the day we all have our own thoughts about sexuality, and our own biases, and we can’t bring that into a room with a patient,” Otten told Croakey in an interview after her session.

She impressed upon clinicians that sex was about so much more than penetration and orgasm, and that it was not a question of quantity (except for procreation purposes) but quality. Otten, whose partner is Paralympian Dylan Alcott, said sexuality encompassed all kinds of bodies and abilities.

Otten shared the story of one patient, who had experienced a great deal of trauma including sexual assault in a psychiatric ward and had a long history of self-harm.

For her, learning to ask for human touch was a huge hurdle, and one Otten had helped to her confront with the help of a ‘professional hugger’.

She recalled another patient, an older female, who came up to her at the AFL after completing her online course in sexual self esteem to tell her how much her sex life had improved.

“My husband doesn’t know I did your course,” the patient told Otten. “This is just something he thinks happens to women when they turn 52.”
Obstetricians, gynaecologists and sexology

Otten said there were plenty of good reasons for obstetricians and gynaecologists to engage with sexology, not least of which was that many of the most poorly understood and mismanaged problems in sexual health, including vaginismus (painful spasm of the muscles in the pelvic floor), were a shared concern.

Procreation and pregnancy – arguably the bread and butter of the specialists gathered for this meeting – were a double-edged sword when it came to sex. Though (and perhaps because) it became a necessary evil, trying for a baby could make sex less enjoyable, while pregnancy and birth could also impact a couple’s sex life, and their sense of themselves as sexual beings, in negative ways.

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**Amy Coopes**
@coopesdetat

Of direct relevance to O&Gs are the flow on effects of pregnancy and birth for sex - desexualisation of certain body parts, pain, prolapse, exhaustion #RANZCOG19

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**Amy Coopes**
@coopesdetat

Why should O&Gs care about sexology? So many reasons! #RANZCOG19

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Why is Sexology relevant for Obstetrics and Gynecology?

- Ob/Gyn are usually the frontline for female patients who are having sexual challenges
  - Vaginismus
  - Vulvodynia
  - Lichen Sclerosis
  - Genital dysmorphia
  - Desire
  - Sex education
  - Hormones
- Sex is important for overall well being, but also in childbearing
  - Is sexuality addressed in all consultations?
  - Not quantity (unless trying for a baby), but quality
- Sex and parenthood: when three threaten two
  - Is sex life healthy/ frequent enough to fall pregnant?
  - What is partners sexuality like? Does the partner have challenges?
  - Sex makes babies and babies spell the erotic disaster in couples
  - How to maintain a certain erotic energy?
Asking the right way

Rather than embarrassed, Otten said most patients would be relieved to have their doctor ask about their sex life, provided this was done in the right way. Failing to bring it up ran the very real risk of leaving patient needs unmet, she added.

She urged delegates to stop avoiding these conversations, refer (with caution as sexology is unregulated in Australia) to experts like herself where they felt out of their depth, and to continue being curious about sex.

“I think it’s a really fundamental part of our wellbeing,” said Otten. “It not only makes us feel really good about ourselves, it’s very good for some conditions as well that might leave us feeling challenged within our body and in ourself.

“It’s good for making babies, it’s good for relationships, and I just think all round it should be a lot of fun.”

* Croakey has deleted the interview with Otten previously published with this story and on our YouTube channel, at her request.
RANZCOG sets gender equity targets

The medical specialty dedicated to women’s health is taking steps to tackle male dominance in leadership positions within its professional body, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Amy Coopes writes:

A series of targets designed to boost female representation at the highest levels of the Royal Australian and Zealand College of Obstetricians and Gynaecologists (RANZCOG) was announced, with the launch of a landmark report acknowledging bias and stereotypes have locked out women and minority groups.

Dr Vijay Roach, President of the RANZCOG, will launch the Gender Equity and Diversity Working Group’s inaugural report in an address at the College’s annual scientific meeting in Melbourne, where more than 1,000 delegates have gathered from across the two countries.

RANZCOG was put on notice about its poor gender equity record at last year’s meeting, when obstetrician Dr Kirsten Connan delivered a forensic, impassioned analysis and call to arms, urging affirmative action to correct a startling imbalance in College leadership.
While an interim quota targeting two additional women to the RANZCOG board is among recommendations contained within the Working Group’s report, targets are largely preferred as the mechanism to drive change.

These include:

- Women should account for at least 40 percent of the RANZCOG Board, with a matched target of 40 percent males to safeguard balance over the longer term (no timeframe specified)
- Thirty percent of College examiners should be female by 2021, reaching 40 percent in 2022
- Women should be at least 30 percent of speakers at College-affiliated events by 2021, rising to 40 percent in 2022 and 50 percent in 2023.

**Signalling intention**

Ahead of the report’s launch, Roach told Croakey: “Rather than quotas, which are either difficult or impossible to meet, by setting a target – something that’s aspirational – we are signalling very strongly what our intention is and what our thought process is.”

Connan, who as Working Group deputy chair co-authored the report, said it was a “forward step and I am pleased that RANZCOG is having this conversation”.

“The question now is whether the report will result in authentic action,” Connan told Croakey.

“I believe for that to happen we now need the broader membership to keep the Board accountable with the [Working Group] recommendations.”

While the Working Group was genuinely committed to advancing equity in the College, Connan said this sentiment was not shared by all RANZCOG members.

“Now is the time for all of our membership to acknowledge the issue, embrace the data, recognise the benefits, and be a part of the change that will shape our College and women’s health, benefiting all,” she said.

In producing the report, RANZCOG become the first medical college in Australia to engage with the government’s **Workplace Gender Equity Agency**.

Despite 83 percent of College trainees being female and gender parity existing at many other levels of the organisation, there is just one woman on the Board, and this has historically always been the case.

In the history of O&G in Australia, just two women have held the office of president – one since the inception of RANZCOG in 1998, and another in the 40 years preceding conglomeration with New Zealand, when RANZCOG was known as RACOG.
“RANZCOG has the highest percentage of female members in comparison to other Australian and New Zealand medical colleges, yet one of the lowest percentages of women in top-level leadership,” the report states.

As recently as 1978, the College was overwhelmingly dominated by men, with 95 percent male membership, prompting a concerted drive to address the imbalance.

RACOG was the first medical college in Australia to introduce part-time training, and by the turn of the millennium 60 percent of O&G trainees were female. Male trainees hit 40 percent that year, and have steadily declined ever since, reaching 20 percent in 2018. The reasons for this are unknown, and warrant further investigation, according to the report.

**Systemic issues**

It is clear that systemic issues are at play, impacting not only women but also minority groups, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, international medical graduates and the LGBTQIA community.

The report states:

> “RANZCOG acknowledges that barriers, including implicit bias and current stereotyped leadership styles, may have impeded leadership opportunities for women and other minority groups.

> These barriers have restricted training opportunities for some members of RANZCOG, reduced opportunities for some members to participate in RANZCOG events and participate in their workplace, and affected participation for some RANZCOG employees.”

While gender equity is the first priority of the Working Group, focus in the longer-term will be on increasing representation of minorities, and addressing their needs.

The report notes that, to achieve population parity, Australia needs to have 3,000 Indigenous doctors, a vast increase on the current level of 200, of whom only two fellows and six trainees are in O&G.

In Aotearoa/New Zealand, just four percent of doctors are Maori and two percent are Pacific Islander, compared to 15 percent and seven percent respectively as a proportion of the population, and RANZCOG has just six Maori fellows or trainees.

**Naming bias**

The roadmap suggests RANZCOG consider using blinded resumes in trainee selection and expand and formalise flexible work, job sharing and parental leave arrangements in partnership with employers.

It also calls on hospitals and other medical workplaces to address gender imbalances in leadership and actively educate doctors on implicit bias.
It makes a number of recommendations around the transparent and consistent measurement of performance, the guarantee of paid parental leave without detriment to employment, and equal pay.

Citing work by Dr Helena Teede, the report notes that gender equity is a systemic issue in medical leadership, with women comprising just 30 percent of deans, chief medical officers and college board or committee members, and just 12.5 percent of tertiary hospital CEOs.

It highlights capacity bias (women are seen as less capable due to family and domestic responsibilities), perceived capability bias (women’s confidence in their ability to lead) and credibility bias (linking of leadership credentials to traditionally male values) as some of the issues at play.

It highlights some of the work done in recent years at other specialist Colleges on this issue, set out in the table below. This includes the adoption of a 40 percent quota for female leadership in the Victorian branch of the Australian Medical Association, and a 40 percent target for the federal leadership of the AMA.

<table>
<thead>
<tr>
<th>Date</th>
<th>Organisation</th>
<th>Policy</th>
<th>Action</th>
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<tbody>
<tr>
<td>2014</td>
<td>Australian Medical Students’ Association</td>
<td>Gender Equity position statement and policy</td>
<td>Inclusive policy for women training in specialties</td>
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<tr>
<td>2015</td>
<td>Royal Australasian College of Surgeons</td>
<td>Diversity and inclusion position statement</td>
<td>Gender quotas</td>
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<tr>
<td>2018</td>
<td>Australian Society of Anaesthesia</td>
<td>Leadership representation for members with young children</td>
<td>Skype, teleconference, childcare expenses to attend face-to-face meetings</td>
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<td></td>
<td>Australian College of Emergency Medicine</td>
<td>Diversity and Inclusion Working Group</td>
<td>Council and Board membership targets (40% female 2022)</td>
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<tr>
<td></td>
<td>International Gynaecological Cancer Society</td>
<td>Gender equity statement</td>
<td>Board representation quotas (50% female 2022)</td>
</tr>
<tr>
<td>2019</td>
<td>College of Intensive Care Medicine in Australia and New Zealand</td>
<td>Gender equity statement</td>
<td>Board and academic meetings representation targets (30% 2019, 40% 2020, 50% 2022)</td>
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<tr>
<td></td>
<td>Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine</td>
<td>Gender equity position statement and action plan</td>
<td>Annual gender metric reporting, speaker representation at academic meetings</td>
</tr>
<tr>
<td></td>
<td>Australian Medical Association</td>
<td>Gender equity statement</td>
<td>Federal leadership target (40% female)</td>
</tr>
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</table>

Weighing up the evidence for quotas versus targets, the report notes that the latter have been adopted as the Workplace Gender Equity Agency’s preferred approach, and while they take longer to show results, offer more discretion and flexibility.

Quotas work quickly and can be transformative, but invite the perception of tokenism and may be seen as conflicting with merit-based appointments, the report says.
Reports from the report launch via Twitter

Helena Obermair @HelenaObermair · Oct 16
“The system, our society, has to change” @RANZCOG_Pres Dr Vijay Roach announcing the Gender Equity and Diversity Working Group Report at #RANZCOG19

Dr Bec Szabo @inquisitiveGyn · 11h
@RANZCOG_Pres @ranzCog Vijay Roach #RANZCOG19 President’s address.

RANZCOG President and RANZCOG - O&G

Dr Bec Szabo @inquisitiveGyn · 10h
Replying to @inquisitiveGyn
Bullying, harassment, sexual harassment is real. Lack of opportunity for leadership for women is real. But we can change and must change says @RANZCOG_Pres @RANZCOG_Pres #RANZCOG19

Dr Bec Szabo @inquisitiveGyn · 10h
@RANZCOG_Pres acknowledging this is only a report and not a statement or policy or action. Accepting criticism that we are not there yet because it takes time. #RANZCOG19

Dr Bec Szabo @inquisitiveGyn · 10h
@RANZCOG_Pres We are going to stop gender inequity @ranzCog

We are going to start the process for change & we are going to continue to listen to our members.

@RANZCOG_Pres #RANZCOG19

We want equality and equity and we want to be leaders in advocates for women’s health says @RANZCOG_Pres
RANZCOG sets gender equity targets

You can track Croakey's coverage of the conference here.

Dr Bec Szabo @inquisitiveGyn

@RANZCOG_Pres moving on to address #genderequity or lack of it @ranzco at all levels in Australia and New Zealand, the barriers and our failure as a college. As revealed by @Connankf last year through @EXCITE_UOM masters. #RANZCOG19

Dr Bec Szabo

@inquisitiveGyn

The result of the process of review is now this @ranzco report. Discussing equity versus equality. Discussing #unconsciousbias and leaky pipeline. Inherent disadvantage does not give equity. We need to change because women are invisible. @RANZCOG_Pres

#RANZCOG19
Calling for advocacy and action on inequities in abortion care

Amy Coopes writes:

Australian women face harmful inequities in access to abortion care, and obstetricians, gynaecologists and their College must do much more to push for change, a major meeting of women’s health specialists has been told.

While there had been welcome progress on abortion care in Australia with the passage of decriminalisation laws in NSW, there was no room for complacency or self-congratulation, speakers told the annual scientific meeting of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in Melbourne.

Drug restrictions, cost, and stigma – especially within the medical profession – are contributing to inequities of access, they said.

The conference was told about so-called ‘conscientious objector’ doctors, who not only refused to provide services but also did their best to stymie those did.

This often took the form of delaying a referral for abortion until 10, 12 or sometimes 20 weeks, according to a doctor from Brisbane who described this practice as “directly harming women”. (The doctor was commenting from the floor in a session and was not identified).
RANZCOG was urged to step up its advocacy in this space and provide greater support for primary care providers, with one of the field’s pre-eminent experts telling the conference that the College was only “a third of the way there”.

It was standing room only at the conference’s sexual and reproductive health session, with delegates forced to sit on the floor and overflow into the corridor as Dr Paddy Moore, from the Royal Women’s Hospital in Melbourne, provided an update on equity of access to abortion both in Australia and abroad.

Moore, one of Australia’s leading voices on abortion (and profiled recently in The Sydney Morning Herald), told delegates she had evolved over the years into someone with a ‘conscientious compulsion’ to not only provide abortion care, but to speak about it publicly. She was prominent during the recent NSW decriminalisation debate.

While legislative reform was of course welcome, Moore said it was only part of the puzzle, with legal protection meaning little if people were unable to access abortion services due to geographic or cost barriers.

Instead of reproductive ‘rights’, which she described as being grounded in the law, Moore said she was an advocate for reproductive ‘justice’, which recognised that, when it came to accessing services, it was not a level playing field.

“There is no room for self-congratulation,” Moore said, noting that the average cost of a medical abortion in Australia was $560. “That is not equity of access.”

A blueprint

Describing equity as a “process” that required political will, Moore detailed a blueprint for progress that included greater training for providers and planning for succession and increased services – especially in the public system, rurally and remotely, and for marginalised groups.

“Governments and health boards have to mandate that women’s health services provide abortion and contraception services,” said Moore, also stressing that women must be able to self-refer.
The importance of this was illustrated during a panel discussion at the end of the session, when delegates shared their frustrations at so-called ‘conscientious objector’ colleagues, who often delayed referrals for abortion until 10, 12 or sometimes 20 weeks.

Rather than “chastening” a pregnant woman into changing her mind, Moore said the research showed such tactics only served to waste patients’ time. The best way to get around obstructive colleagues was to allow women to directly self-refer, Moore said.

She urged those in the session to “start the conversation” with objectors in their ranks, saying no viewpoint was fixed, even among the most trenchant opponents.

“I have discovered that if I talk to the junior staff, the medical students, let them hear the women’s stories and talk to them about their conflicted feelings, there is movement,” said Moore.

**Shifting viewpoints**

This was echoed by Professor Lesley Regan, president of the UK’s Royal College of Obstetricians and Gynaecologists, who was in the audience for the session.

Regan shared the success of a US program called the **Ryan Fellowship in Family Planning**, which requires involved doctors – even those who describe themselves as objectors – to have an observer role in the abortion care process.

After spending time with women seeking an abortion and understanding more about their decisions, Regan said more than 90 percent of objectors – termed ‘partial participants’ by the program – were converted to full participation.

In her earlier keynote, Regan described abortion and contraception as the two ‘elephants in the room’ for maternal mortality globally, and in meaningful progress towards **Sustainable Development Goal 5**: Achieve gender equality and empower all women and girls (an interview with Regan about this and other issues will be reported in later coverage of #RANZCOG19).
Language matters

Regan and others stressed the importance of language and using terminology such as ‘anti-choice ‘(not pro-life), 'conscientious commitment' as well as objection, and 'abortion care' rather than 'termination of pregnancy'.

RANZCOG ought to have a leading role in these discussions, according to Moore and de Costa.

Moore said the College, and the profession more broadly, had “abrogated this responsibility” for too long. She also called for RANZCOG to drive greater education around sexuality and respectful relationships.

Moore’s take-home messages, in keeping with the ASM theme ‘Stop. Start. Continue’ were that RANZCOG:

- STOP sidelining sexual and reproductive health
- START prioritising equitable service provision, and a dialogue within the profession about how conscience, commitment and objection sits alongside this goal
- CONTINUE developing a curriculum for sexual and reproductive health, and advocating for appropriate and affordable services locally, nationally and regionally.

She also impressed on colleagues that the US experience, which she shared in some detail having just returned from sabbatical there, showed you “can’t take your eye off the political ball”.

Moore described clinics having their electricity, water and waste collection shut off, and said opponents had “swapped Roe v Wade to just shutting clinics down”.

Unprecedented

Professor Caroline de Costa, who was the first doctor in Australia granted permission to use the abortion drug mifepristone (also known as RU486), took delegates through a potted history of the drug, which she said had been politicised in Australia unlike any other medicine, and in a way unseen anywhere else in the world.

The Therapeutic Goods Administration restricts prescription of mifespristone (usually sold in combination with misoprostol as the preparation MS TwoStep) to specific groups of doctors, and requires all other providers to complete a training module before they can prescribe.

The TGA has also imposed specific conditions on the single group that distributes the drug in Australia – MS Health, which was established by Marie Stopes for this specific purpose – including provision of a 24-hour telephone aftercare service.

“These special requirements are not because the drug is difficult to use or poses dangers to Australian women,” said de Costa, outlining four major Australian studies showing MS TwoStep was safe, acceptable and effective.

“They were instituted in response to the political pressure applied to the TGA by politicians opposed to abortion.”

Not only were these restrictions unparalleled globally, de Costa said they had – as intended by those who agitated for them – a chilling effect on abortion provision, contributing to stigma both in broader society and within the medical profession. Just 1,500 of Australia’s 35,000 GPs are registered as MS TwoStep providers.
Education and support needed

Even GPs who are registered still face the additional hurdle of finding a pharmacist who is prepared to get the drug in and supply it to their patients, which was not always easy outside of metropolitan centres, added Dr Deb Bateson, who is medical director of Family Planning NSW.

Bateson said this was sometimes a case of conscientious objection to abortion, but more often than not was down to the practice being out of a pharmacist’s comfort zone, underscoring the need for education and support.

Moore, de Costa and Bateson all stressed the need for GPs to receive greater support from RANZCOG and its members to offer medical abortion.

Using Victoria’s MyOptions website, where patients can search for providers, Moore demonstrated that when a doctor knew there were other doctors in their area offering abortion care who they could contact for advice and support, they were more likely to undertake the training themselves, resulting in service provision ‘clusters’.

“But what we really need is for people to set up in those blank areas of the map,” Moore said.

De Costa urged the College and its members to continue lobbying for the TGA to lift the restrictions on MS TwoStep, and to step up its education and support of GPs and trainees in mifepristone use.
From Twitter

See this Twitter thread of Dr Paddy Moore’s presentation.

See this Twitter thread of Professor Caroline de Costa’s presentation.

See this Twitter thread of the panel discussion.
You can track Croakey's coverage of the conference here.

Calling for advocacy and action on inequities in abortion care
You can track Croakey’s coverage of the conference here.

Calling for advocacy and action on inequities in abortion care

#RANZCOG19

Progress in Australia

• Regulated by the states and territories rather than the Federal Government

• Abortion remains in the criminal code in South Australia

• South Australia has a draft bill under review

• Time restrictions are in place in some states, ranging from 20 weeks in Western Australia, 23 weeks in Northern Territory and 28 weeks in South Australia

• Tasmania, Victoria, New South Wales, ACT, Queensland & Northern Territory also implement safe access zones around termination clinics

Slide by Prof Regan

Amy Coopes @coopesdetat · Oct 16
Regan presenting data showing only 30% of abortions in England & Wales now provided by NHS. Real access problems, lack of choice for women #RANZCOG19

Show this thread

RANZCOG · O&G @ranz cog · Oct 16
@regan7 says 90% of global maternal deaths are preventable. Unsafe abortion is responsible for 16% of maternal mortality, ahead of pre-eclampsia and obstructed labor #RANZCOG19
You can track Croakey's coverage of the conference here.

Calling for advocacy and action on inequities in abortion care

#RANZCOG19

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RANZCOG - O&G @ranzog - Oct 16
@iregan7 says 90% of global maternal deaths are preventable. Unsafe-abortion is responsible for 15% of maternal mortality, ahead of pre-eclampsia and obstructed labor #RANZCOG19

Dr Bec Szabo @inquisitiveGyn - Oct 16
@iregan7 @RCOObsGyn @ranzog discussing the invocation of the gag rule and impact on abortion law and care of women and girls worldwide. Prevents access to #contraception and #abortion and increases abortion not reduces because of loss of access to contraception. #ranzog19

Dr Bec Szabo @inquisitiveGyn - Oct 16
In the next hour there will be 8 deaths worldwide from abortion and much of those in young girls. Abortion care provision is vital to save the lives of girls and women worldwide. @iregan7 @RCObsGyn @ranzog #ranzog19

Prof Lesley Regan - if you care about mothers dying, you HAVE to care about #contraception and safe abortion @iregan7 #RANZCOG19
Immediate initiation of #LARC after #abortion has been shown to reduce the rate of repeat abortion. Learn more with this article: ogmagazine.org.au/20/3-20/world-... #RANZCOG19

Read the article here.

#RANZCOG19 Throughout history women have sought to control their fertility and #abortion has always been a part of this. Learn more about the history of abortion with this article by @anzjog's Editor in Chief, Prof Caroline de Costa:

‘For the sake of the woman’s life and health’ – O&G Magazine
Two truths about abortion emerge from history: women with unintended unwanted pregnancy will seek termination ...

Read the article here.
For doctors and other health professionals, some advice on caring for transgender patients

Dr Deb Bateson presents at #RANZCOG19. Photograph by Amy Coopes

Amy Coopes writes:

Stop assuming, start educating yourself, and continue developing the skills to deliver affirming, appropriate care to transgender patients.

That was the message to obstetricians and gynaecologists gathered for an annual summit of Australian and New Zealand women’s health specialists in Melbourne, with the theme, Stop. Start. Continue.

Though it was focused on contraceptive choices, Dr Deb Bateson’s talk in a popular session on sexual and reproductive health offered some important context and practical advice for healthcare workers on the inequalities and systemic barriers confronting trans patients seeking care.

Bateson, who is medical director of Family Planning NSW, said one of the major issues for trans people navigating the health system was that they were expected to educate providers over and over, a burden that was not only unreasonable but contributed to access barriers and poorer outcomes.

http://bit.ly/2qFFlc6
Previous trauma or negative experiences with health providers were a significant deterrent for many, as was fear of transphobia, stigma, prejudice, discrimination and abuse. (See here for previous Croakey coverage of this issue, including some sobering statistics on trans and gender diverse experiences of the healthcare system.)

Inconsistent, sometimes incorrect advice on matters, including Pap smears was also a problem, along with misconceptions about contraception for trans patients, whether they were assigned female or male at birth, Bateson said.

She shared the success of Sydney’s Check OUT clinic, run by ACON and Family Planning NSW under the tongue-in-cheek motto ‘At Your Cervix’, which offers HIV and STI screening and cervical screening for all LGBTQI+ people with a cervix. It is run by community peer workers and trained sexual health nurses.

Importantly for delegates at the annual Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Bateson said the skills and knowledge of health professionals, and a lack of resources and referral networks represented a real barrier in trans health, and one she was there to – hopefully – help them address.

The session followed a powerful plenary address from paediatric gynaecologist, Dr Charlotte Elder, at the 2018 RANZCOG ASM, on delivering trans-affirming care. We covered the session in detail here.

Avoid assumptions

Bateson reminded colleagues that transgender patients were a diverse group who engaged in a range of sexual practices and relationships and who may, or may not, have elected to undergo hormonal or surgical affirmations.

Their experiences of sex, and sexual and reproductive health were unique, and this was an emerging field of medicine encompassing both general and specific health needs, including but not limited to:

- Cervical screening, colposcopy and cancer care
- Fertility services
- Contraception and abortion care
- Pregnancy and antenatal care.

The single most important thing Bateson said delegates could do was avoid assumptions, whether this was about a patient’s gender, body, sexual orientation or sexual partners.

Rather than assuming, Bateson encouraged doctors to ask about all these things – not only in the interests of disclosure, but because it helped to foster trust.
It was also critical not to make clinical assumptions about issues like screening and contraception without a firm knowledge base, she added, sharing some startling data from the US showing that a quarter of trans men had experienced an unintended pregnancy after transitioning, believing that testosterone had a contraceptive effect.

This misconception was prevalent not only among trans men but also their doctors, said Bateson. While testosterone therapy (or ‘T’) could cause periods and ovulation to cease, it was not reliable as a form of contraception, she added, impressing upon colleagues that they needed to discuss alternative methods with anyone engaging in ‘penis in vagina sex’, particularly given that pregnancy was an absolute contraindication for continued administration of T.

When having these discussions, Bateson said it was important to weigh a host of other factors for trans masculine patients, including desire for amenorrhea, body dysphoria, and how methods containing oestrogen would counteract testosterone therapy.

She also counselled colleagues to consider the increased risk of HIV transmission for patients on T due to increased friability of the vaginal mucosa, a side effect that she said could also make speculum insertion more uncomfortable.

She took delegates through the pros and cons of various methods, ranging from condoms (protection against STIs but relatively high failure rate), tubal occlusion (permanent), and a range of progestogen-only methods (variable efficacy, unpredictable bleeding), as well as intrauterine devices such as the Mirena (efficacious, but may require sedation in cases of pelvic dysphoria and/or topical oestrogen to reduce discomfort).

Among AFAB (assigned female at birth) trans masculine people, Bateson said depot (DMPA) injections and copper IUDs (hormone free) were the preferred methods, and with a subcutaneous self-injectable DMPA preparation called Sayana Press on the way, depot could soon be most people’s go-to choice.

Given the very real risk of pregnancy, Bateson implored colleagues not to forget the morning-after pill and copper IUD as options following unprotected vaginal intercourse.

For AMAB (assigned male at birth) trans feminine people, Bateson said options were currently limited to condoms and vasectomy. Like testosterone therapy, though oestrogen therapy and testosterone blockers decreased sperm count and motility, they were not reliable forms of contraception.

In her final slide, Bateson had one simple message:

“Stop to consider, start to build knowledge and continue to develop skills.”

The Australian Standards of Care and Treatment Guidelines mentioned above are available here.

See this Twitter thread summarising Bateson’s presentation.
Challenges to consider

In pre-meeting workshops, Dr Ruth McNair, a global leader in LGBTQI health at the University of Melbourne, also delivered a session on trans health in which she singled out some of the challenges for doctors working in this space:

- Rapidly changing language, terms, and diversity
- Increasing expectations under an ‘informed consent’ model
- Fertility preservation
- Cancer risk and screening best practice
- Bone health
- Evidence gaps
- A movement from specialist to generalist care for trans and gender diverse patients
- Rapidly increasing demand for services
- Lack of available training.

Terminology matters

Melbourne-based paediatric gynaecologist Professor Sonia Grover laid out some basics for working with trans patients, including inquiring about what pronouns a patient would prefer and what name they went by.

It was essential to frame this appropriately, by asking for example ‘what would you like me to call you’ or ‘what do your friends call you’, and to use acceptable terminology, such as ‘top’ or ‘chest’ surgery instead of ‘mastectomy’.
For gynaecologists treating trans men, Grover said pelvic pain, bleeding, endometriosis and cervical/STI screening were some key things to remember, as well as hysterectomy and oophorectomy.

With referrals to the Royal Children’s Hospital Gender Dysphoria Service increasing one hundredfold between 2003 and 2014, Grover said it was important to get this right, not just for O&G specialists but for every healthcare worker coming into contact with trans patients.
To reduce stillbirths, we must tackle substandard care

Bereaved families gathered in Melbourne on October 15 for the Victorian Government’s inaugural commemorative service to mark International Pregnancy and Infant Loss Remembrance Day.

Photograph by Amy Coopes

Amy Coopes writes:

About 200 stillbirths in Australia every year are preventable, with up to a third of all cases due to substandard care, a major meeting of the country’s obstetric doctors heard in Melbourne, where the importance of communication and education was emphasised as the Federal Government rolls out a major new initiative in antenatal care.

Health Minister Greg Hunt launched the Safer Baby Bundle in Canberra, a national project aimed at reducing the number of stillbirths in Australia after 28 weeks’ gestation by 20 percent by 2023.

The Safer Baby Bundle launch, which was held on International Pregnancy and Infant Loss Remembrance Day, coincided with the annual scientific meeting of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the peak training and advocacy body for women’s health specialists, and it was the focus of a packed session for delegates.
You can track Croakey's coverage of the conference here.

To reduce stillbirths, we must tackle substandard care.

The Safer Baby Bundle works through a targeted education program for doctors and expectant mothers targeting five key areas:

1. Smoking cessation
2. Foetal movement awareness
3. Maternal sleeping position
4. Detection and management of foetal growth restriction
5. Timing of birth for women at risk.

Similar programs have been rolled out with success overseas, reducing stillbirth rates by one-fifth in Scotland and the UK, and a Senate inquiry into Australia’s stillbirth rate – 15th highest in the world and little-changed over the past two decades – recommended rollout of such an initiative here.
Calls for action

The RANZCOG session took attendees through the detail of the bundle, which will accrue Continuing Professional Development points for members of RANZCOG, the Australian College of Midwives, and GPs.

The session also featured powerful talks from stillbirth advocate Claire Foord and Torres Strait Islander obstetrician Dr Beth Campbell, both of whom shared insights from their lived experience in the system.

Townsville specialist Dr David Watson also made the case for Aboriginal Controlled Community Health Organisations and Birthing on Country services, showing that they had a demonstrable impact on maternal and perinatal outcomes and would be key to closing the gap on stillbirth in Indigenous communities.

Setting the scene for the session, neonatologist Dr Adrienne Gordon said the Safer Baby Bundle was “all about what we know works but isn’t being done” in Australia, where stillbirth rates are 35 percent higher than in the best-performing countries and where it was estimated that 20-30 percent of all stillbirths were attributable to substandard care.

Professor Euan Wallace, an obstetrician who is also the CEO of Safer Care Victoria, said about 200 excess preventable stillbirths occurred each year in Australia. This was laid out in forensic detail by the Senate inquiry report, which he described as “galling” reading.

Victoria has led the way on this issue, establishing a perinatal data registry almost 40 years ago. Under Wallace’s stewardship, it was also the first state to roll out the Safer Baby Bundle at a state level earlier this year.

But Wallace said simply reporting the numbers was not enough:

- “We have to do something with those numbers.
- And perhaps as a profession we haven’t been doing enough.”

Importance of ACCHOs and Birthing on Country

Gordon emphasised that while the Safer Baby Bundle was an important initiative, it must be accompanied by improvements to maternity services, particularly increased access to midwifery continuity of care models for all women – especially those at risk.

This was very much supported by Watson’s presentation, which showed that for Indigenous women, ACCHOs and Birthing on Country services had transformative potential for perinatal mortality.

In Queensland, where he practised, Watson said Indigenous women were 1.7 times more likely to have a stillbirth, and that gap was wider still for Torres Strait Islander women (12 in every 1,000 births) compared with Aboriginal women (9.3 in 1,000).
He presented a study from Townsville showing that, compared with care as usual, antenatal services delivered through an ACCHO framework halved the rates of preterm birth, delivered babies that were 150g heavier on average, and – most importantly – significantly reduced perinatal deaths.

Among the ACCHO group, the mortality rate was lower than not only the control group but also better than the Queensland average. Watson presented studies from Brisbane and Perth that mirrored the Townsville findings.

Watson also revealed that, in contrast to non-Indigenous women, where congenital anomalies were the leading cause of perinatal death, among Indigenous women the majority of stillbirths were classified as ‘unexplained antepartum death’.

This reflected, in part, that rates of autopsy were much lower, he said, sharing a recent paper that explored some of the reasons why.

Unsurprisingly, the way in which the conversation was handled – between clinicians and parents about having an autopsy done, whether they want one, why it would be done, what it would involve – was shown to have a major impact.

Listen to women

Watson’s colleague, Dr Beth Campbell, underscored the impact of institutional racism and the legacy of interventionist policies on Indigenous women’s experiences.

Campbell, whose family are from Saibai Island in the Torres Strait, said many aspects of routine antenatal care weren’t a priority in her community and “it is not that women don’t want to engage or present, but transport and other things taken for granted on the mainland” were real issues.

For many Indigenous women, Campbell said English was their second, third, fourth or even fifth language and “the more they say ‘yes’, the more they mean ‘I don’t know what you are talking about’.”

Instead of asking so many questions, she urged colleagues to stop, allow spaces for silence in these consults, and really listen.

If RANZCOG was really serious about improving antenatal care for Indigenous women, Campbell said they needed to do more on equity of representation, with just three fellows, five trainees and a handful of diploma affiliates who identified as Aboriginal or Torres Strait Islander.

Improving diversity at the College has been identified as a major issue, with a Working Group report launched at the ASM setting targets to boost the number of women in leadership, and highlighting Indigenous representation as the next priority for action.

Communication is critical

Communication was also a major theme for stillbirth educator Claire Foord, who delivered a stirring keynote on the death of her daughter, Alfie, at term, in 2014. She detailed a series of lost opportunities and miscommunications with her health care providers in the final weeks of her pregnancy which, had they gone differently, may have saved Alfie’s life.

Foord urged obstetricians to talk about the risks of stillbirth from the very first visit, saying too many families like hers were “blindsided” when it happened to them.
“Things are only rare until you look at them through your own eyes,” Foord told a packed auditorium of specialists. “I think it’s way too common not to be talked about. If we could see these lives being lost in the street we would be doing something about it.”

Instead of closed questions like ‘is your baby moving’, Foord urged doctors to invite a conversation with their patients by asking them to describe the movements, and to explain that it wasn’t just how often their baby moved, but the strength and pattern or timing that mattered.

She also encouraged clinicians to compassionately and comprehensively debrief their patients after a stillbirth, not only to help with grief and healing but because, just like an autopsy, it could offer important clues to inform future care.

Had someone asked Foord these questions, she said she could have told them Alfie’s movements had changed, from a karate kicker and dancer to a placid, docile child who, after one last frenzied evening, was forever still.

Foord said she liked the term stillbirth because “it is factual, and it is also kind”, recognising that the child was a child, a life, and that for the mother, “it is still birth”.

Watch our interview with Foord

Examining the evidence

As well as online learning modules and face to face training for obstetric care providers, the Safer Baby Bundle includes best practice guidelines, clinical checklists and pathways and audit tools to assess performance.

Gordon took her colleagues through the evidence for the various elements of the bundle, drawing on a survey of maternity hospitals to identify gaps between best practice and actual care across the five domains.

Of the five, she said timing of birth for at-risk women – the subject of intense debate across numerous sessions at the ASM – would be the most tricky to navigate.

She presented some of the most important considerations (on the following page).
To assist clinicians with decision-making, Gordon said a stillbirth risk calculator using some of this data would be rolled out in Australia over the next 12 months, though Professor Sue Walker, director of perinatal medicine at Melbourne’s Mercy Hospital, questioned whether this would be more meaningfully framed as a ‘safe to stay’ algorithm.

She was suggesting that rather than the algorithm having an emphasis on when to get a baby out, it would be more meaningful (and more acceptable to clinicians and parents) if it was framed as a calculation of safety to keep the baby in utero.

The conference heard many discussions about how clinicians convey, and how patients understand and process risk, striking the balance between undue anxiety and not adequately grasping the gravity of potential consequences.

Several sessions explored the need to strike a balance between intervening in the right circumstances and the risk of iatrogenic harm, including a plenary on foetal growth restriction (see a Twitter thread here), keynote on induction of labour versus expectant management from international expert Bill Grobman (thread here), and a prize-winning paper from medical student Roshan Selavaratnam showing increasing delivery and admission to NICU of babies screened as small who were actually not at risk (in this thread).

One important theme that emerged from these discussions was that, while improvements to screening methods were welcome, any new tools and techniques needed to be generalisable across a range of maternity settings, and not just available in tertiary centres, given that stillbirth rates increase the further a woman lives from a major city.

According to the Australian Institute for Health and Welfare, babies born in remote and very remote Australia are 65 percent more likely to die during the perinatal period compared with major cities or inner regional areas.
Healing service

Meanwhile, in Melbourne on 15 October, hundreds of people attended a remembrance service for bereaved parents, families and friends affected by pregnancy and infant loss (watch these videos from the event).

Victorian Minister for Health Jenny Mikakos told those attending:

"The death of a baby or a child is an incredibly difficult topic for many people, which means it is often a silent and unspoken grief for many parents.

It is a profound loss, a devastating loss, an individual loss but a loss that is also felt by siblings, by grandparents other extended family and close friends.

Recognition of the loss of a baby or child by work colleagues, by friends and our wider community is a crucial step in acknowledging bereavement and starting conversations to reduce stigma and to help people get the support that they may need.

It is important that parents that have lost their babies are recognised as parents too, whether they have surviving children or not. I understand the significance this acknowledgment has, and as a community we must support all parents with these difficult conversations.

That's why events like tonight are so important.

They're about coming together to honour and to acknowledge those babies whose lives have been lost through miscarriage, stillbirth or newborn death... Your loved ones will never be forgotten, and tonight we treasure them, we cherish them, and we remember them."

Claire Foord had earlier described the annual day of remembrance as a chance for health care workers to join with their patients in commemorating babies lost.

• Read more about the Safer Baby Bundle session in this Twitter compilation.
Dr Alyce Wilson @AlyceNWilson - Oct 15

Let's reduce stillbirth by 20% through implementation of #SaferBabyBundle.

START talking about stillbirths
STOP preventable stillbirths by implementing what we know works
CONTINUE to strive for best outcomes for mothers and babies
@AdrienneOz @CREStillbirth ranzcg19
Chronic pelvic pain: a complex condition requiring informed care

1. Remember that CPP is a symptom that deserves multi-organ and multimodal therapy. It’s not just endometriosis.

2. When evaluating patients with chronic pain, screen for clinical features of central sensitization:
   - Chronic widespread pain
   - Fatigue, cognitive dysfunction
   - Disability and emotional distress (Depression, Anxiety, Sleep Disturbance)
   - Failure of gold-standard therapies

3. If central sensitization is suspected, consider multi-modal therapy pharmacologic and behavioral therapies for pain, fatigue and their functional consequences (e.g. sleep dysfunction)

The complexities of chronic pelvic pain were discussed in-depth at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) annual scientific meeting in Melbourne.

Amy Coopes writes:

Chronic pelvic pain, described as “one of the most enigmatic conditions in gynaecology”, encompasses so much than endometriosis and is a multifactorial, complex condition, according to speakers at a recent medical conference.

Affecting one in nine Australian women aged 40-44, according to a recent report by the Australian Institute for Health and Welfare, chronic pelvic pain involves links to other pain syndromes, neurological changes, and has a strong psychological dimension requiring multidisciplinary treatment.
Chronic pelvic pain was front and centre at the RANZCOG annual scientific meeting, with a plenary session featuring speakers from a host of disciplines, including physiotherapy and psychology, as well as a focus on priorities in endometriosis.

The Federal Government nominated the condition as a research priority last year, unveiling the first-ever National Action Plan for Endometriosis and pledging $15 million to advance this agenda.

Dr Sawsan As-Sanie, past president of the International Pelvic Pain Society, was keynote speaker for the plenary session. She delivered a masterclass in the drivers, diagnosis and management of chronic pelvic pain, which she described as “one of the most enigmatic conditions in gynaecology”.

She said the condition was rarely commensurate with what lesions (if any) could be seen.

**A vicious cycle**

Instead, As-Sanie said the evidence pointed to chronic pelvic pain being all about the brain, with changes seen in structure, volume and function, and the condition often featuring a constellation of other symptoms, including poor non-restorative sleep, memory problems, mood disorders and an exaggerated response to both internal (bodily functions) and external (sound, light) stimuli.

Characterising it as a “widespread disorder of sensory dysregulation” at the level of the central nervous system, As-Sanie said chronic pelvic pain was just one of a number of chronic pain syndromes that, along with chronic fatigue syndrome and fibromyalgia, also affected the bowel, bladder and vulva, and shared features such as multifocal widespread pain, exacerbation during times of stress and a poor response to opioids.

Chronic pain syndromes are up to two times more common in women and had strong genetic and familial underpinnings, she said.

Patients with chronic pelvic pain often reported a higher lifetime history of pain (for example, headaches and period pain), and As-Sanie said gender bias and a tendency to dismiss or downplay pain reports – particularly from adolescents and young girls – was very much still an issue in the health system.

Given this, As-Sanie said it was so important to take a thorough history before resorting to surgical interventions that would ultimately be futile.

Instead, she urged colleagues to understand chronic pain as a vicious cycle in which fatigue and the functional consequences must be addressed.

She presented evidence showing that, for these patients, non-pharmaceutical therapies including education, aerobic exercise and cognitive behaviour therapy (CBT) were superior to drugs, and shared some comprehensive resources for doctors and patients.

**Key points**

As-Sanie had seven key messages for her colleagues:

1. Chronic pelvic pain is a symptom, and there are many overlapping pathways that lead to it
2. Each woman will have a unique combination of peripheral and central mechanisms at play
3. Women with endometriosis and/or chronic pelvic pain are at increased risk of developing other chronic pain conditions
4. Patients with central sensitisation, the key driver of such conditions, have more acute pain postoperatively and are slower to recover

5. They respond differently to therapy, and surgery is less likely to help with their symptoms

6. Early treatment of the initial insult can help prevent transition from acute to chronic pain; treatment delay associated with increased connectivity between pain regulatory regions in the brain

7. Hysterectomy is not always a cure for all women with endometriosis or chronic pelvic pain.

Watch our interview with As-Sanie

An ethical imperative

Physiotherapist Jen Langford stressed the importance of a biopsychosocial approach, talking through the physical and psychological domains. ‘Quiet the pelvis and calm the nervous system’ was her mantra, she said.

The single most valuable question clinicians could ask their patients was “what do you believe is going on?”, Langford said, characterising her role as one of partnership, validation, empowerment and promotion of the self-efficacy of her patients.

She also reflected on the importance of language and beliefs, and of educating patients about their pain, which she described as an ethical imperative.

This was a theme picked up strongly by Associate Professor Christina Bryant, a psychologist who offered some startling statistics and insights into living with chronic pelvic pain.

About half (48.6%) of the women in one study had experienced physical or sexual abuse, and one-third screened positive for post-traumatic stress disorder, Bryant said, with the odds also greatly increased of substance use (4.6x) and mood disorders (2.3-2.7x), with another study showing 86% had depression (compared with 38% of controls).

Chronic pelvic pain came at significant personal cost, Bryant said, with consequences for employment, social and intimate relationships, self esteem and parenting abilities.

Professor Sonia Grover, a specialist in paediatric gynaecology, painted a similar picture on chronic pelvic pain in her presentation on caring for vulnerable populations (see tweets in this thread).
Understanding and managing chronic pelvic pain was crucial given how common it was, affecting the same proportion of the population as back pain, she said.

Among adolescents, it had been found to have more significant impacts on quality of life than juvenile arthritis or cystic fibrosis, Grover said.

She offered some advice for clinicians (below) and reminded them not to forget their trans patients (read our story on trans health from #RANZCOG19).

### Multidisciplinary approaches

Bryant said chronic pelvic pain patients tended to feel misunderstood by their treating doctors, isolated and alone, and became fixated on the idea that the next test or investigation would be “the one” to solve their problems.

Though there was usually a strong psychological element to their experience of the pain, they often resisted attempts to address these, Bryant said.

While there wasn’t much evidence for the efficacy of any one approach, including CBT, Bryant said there was some support in the research for multidisciplinary management, while mindfulness was emerging as a promising strategy.

For treating teams, a thorough pain history with an emphasis on functional impairment, beliefs, goals and coping strategies was essential, Bryant said, along with inquiring about a patient’s psychological and trauma history. She also stressed the role of patient education.

In a panel session to conclude the plenary, As-Sanie cautioned against an undue emphasis on trauma, describing it as just one piece of the puzzle and counselling colleagues to begin with symptoms.

Bryant echoed this warning, saying trauma was incredibly skilled and complex work and “you don’t want to entrust your trauma to just anyone”.

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**People with chronic pain**

- Chronic or persistent pelvic pain
  - Manage the symptoms
  - Manage the symptoms early (recurrent pain predisposes to chronic pain; Hard, G. et al 2014, AJOG 2014; 210-210)
  - Recognise the associated (pain) symptoms - sleep, bowel, bladder, sexual function
  - Ask her what her priorities are...
    - And...
    - Does she need a physio?
    - Does she need referral to a pain psychologist?
    - Does she need an exercise physiologist?
    - Does she need to attend a pain education course/ or access to pain education material?
  - Are you comfortable to use TCAs, Gabapentin, Pregabalin as part of your pain management?
  - What do you prescribe to help sleep?

15/10/19 RANZCOG ASM
Professor Peter Rogers, who has worked in endometriosis research for almost 30 years, said O&G had – as a specialty – “dropped the ball” on endometriosis for too long, and it had only been through the dovetailing of patient activism and political will that progress was now being made.

He said data collection (“we can’t talk sensibly about the scope of the problem”), detection (the “holy grail” of which would be a non-invasive test or marker), and management (“to put it bluntly, we don’t know what we are doing”) were priority areas for research.

Read the full Twitter thread from the pelvic pain session.
Heed the lessons from the pelvic mesh scandal

Slide presented by Dr Ranee Thakar, president of the International Urogynecological Association, at #RANZCOG19. Photograph by Amy Coopes

Amy Coopes writes:

A leading medical specialist has called for a paradigm shift to stop harmful commercial influences on clinical practice in the wake of the pelvic mesh scandal.

Dr Ranee Thakar, president of the International Urogynecological Association, urged gynaecologists to learn the necessary lessons from the mesh controversy that had engulfed their specialty.

In an address to the RANZCOG annual scientific meeting (ASM), she explored how and why ‘mesh’ had become a “four-letter word”.

“What follows is really a tale of travesty,” said Thakar of the series of regulatory and professional failings that allowed mesh products to gain traction and flood the market before they had a robust evidence base.

Ease of use, quicker recovery and a perception among gynaecologists that they were better for patients were some of the reasons Thakar gave for the popularity of the mesh products.

But she also offered a damning assessment of the role of industry partners, researchers, academics and physicians, calling for a “paradigm re-shift” to put undue influences at arm’s length from clinical practice.
“Otherwise this specialty will be dead,” she said.

Thakar pointed to fragmentation and the regulation of these devices being on a voluntary rather than mandatory basis worldwide, the uneasy financial relationship between industry and research, and the training and throughput of surgeons.

She noted that most mesh procedures had been found to have been done by non-board certified personnel (or registrars).

She also reminded colleagues that clinicians had driven the uptake of mesh products, pushing for alternatives to the products and procedures then on offer.

Thakar urged those who considered themselves innovators to “curb your enthusiasm” and restrict the use of new technologies to research settings, with adequate training (including simulation) essential once new devices and techniques had enough evidence to enter clinical practice.

Amy Coopes 🍃 @coopesdetat - Oct 14
Replying to @coopesdetat

Thakar's take home messages from mesh. 'Otherwise this speciality will be dead' #RANZCOG19

Stop. Start. Continue

The issue of training, simulation and surgical volumes was also explored by Sydney surgeon Professor Jason Abbott, who urged colleagues to “stop thinking we can be good at everything”.

(Read more about simulation in this Twitter thread by Dr Rebecca Szabo, summarising her presentation to the ASM).
Heed the lessons from the pelvic mesh scandal

Stop thinking we can be good at everything
Stop core training in outdated surgical modes

Start recognising the changing nature of procedural gynaecology – including volumes and limits
Start a hysteroscopy training program at core level given the volume of procedures both at training level and at Fellow level
Start the conversation around sharing remuneration for referrals

Continue to monitor your own surgical skillset
Continue to edit out procedures of high complexity with low volume if there is a colleague who will provide a better outcome for the woman
Heed the lessons from the pelvic mesh scandal

Croakey

#RANZCOG19
Take heed

Thakar also stressed the importance of patient involvement in medical innovation, not just at the point of trial and rollout but from the earliest stages of conception.

She called for consumer representation at every level of medical governance, whether committee, council or board.

RANZCOG President Vijay Roach took the opportunity to again apologise to those harmed by mesh products, following Thakar’s address:

“Our profession has had to navigate the failure of systems, and ourselves, with the improper use of vaginal mesh that has had significant consequences for many women.

While much of the blame lies with medical device companies and poor regulation, the College recognises that we too hold responsibility.

We are actively supportive of better training and regulation.

We acknowledge that, when surgical complications occur, it is the patient who suffers.”

In an interview with Croakey at the conclusion of the conference, Roach said Thakar’s presentation had been one of the highlights of the meeting, and wholeheartedly endorsed her call for the profession to heed the lessons of the mesh controversy.

“We absolutely do acknowledge the role of the medical profession in that failure,” said Roach. “I don’t think it’s good enough to simply point to the government or to the regulatory bodies or the device manufacturers and say that it was all their fault”:

“We failed to investigate the potential complications of mesh adequately; even more importantly we failed to listen when women started to report the negative consequences of mesh. We failed to validate their pain, we failed to recognise that they were experiencing complications, and we didn’t do something about it when we should have.

“There were many opportunities for us to stop using mesh at an earlier stage and I think that it’s better for the medical profession, it’s more honest, for us to acknowledge our role in that and to address that.”

Profit drivers

In a panel discussion following Thakar’s talk, Roach had questioned the significance of self-interest, and not just for industry, which he described as the “low-hanging fruit” for criticism, but within their own specialty.

Professor Ben Mol, who head up Monash University’s evidence-based women’s health care research group and was also on the panel, said the world was driven by profit, and anything that offered a financial return took on a life of its own.

“That, I am afraid, is also true in medicine,” he said.

Mol said the only way to truly address this issue was reform of financial incentive systems, giving the example of IVF where he proposed remunerating specialists per successful pregnancy rather than per cycle performed.
In an earlier keynote, Mol advocated for what has been dubbed the third, or **moral era in medicine**, the central tenets of which included a rejection of protectionism, greed and complex individual incentives, and a shift of emphasis from revenue to quality, transparency, civility and to “hear[ing] the voices of the people served”.

Mol noted that some half of all commonly-used treatments in the UK were of unknown effectiveness, and research had shown a similar proportion within obstetrics and gynaecology in the Netherlands, describing this as the “elephant in the room” for O&G as a specialty.

He examined a number of common interventions including use of assisted reproductive technologies, induction of labour, caesarean section and hysterectomy, showing that, for each, there were considerable practice variations, including equity of access.

All were increasing in Australia, and Mol questioned whether clinicians properly considered the consequences of these procedures or adequately counselled patients about them.

Echoing Thakar, Mol said it was about striking the right balance between innovation and re-evaluating what was already being done.

Read a Twitter thread summarising Thakar’s presentation.

Read a Twitter thread summarising Ben Mol’s presentation.

In presenting the media award, as per the tweet below, Roach said the piece had been chosen, in part, because it had given a voice to victims.
**Women’s health conference highlights the toll of violence and reproductive coercion**

Intimate partner violence and reproductive coercion are common, significantly increase the odds of adverse maternal and perinatal outcomes, and ought to be screened for by all women’s health specialists, a recent summit of Australian and New Zealand obstetricians and gynaecologists was told.

Dr Vijay Roach, president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), has identified domestic and family violence, and mental health as two key issues for the College as it steps up its advocacy on the social determinants of women’s wellbeing.

Family violence was highlighted in several talks at the recent RANZCOG annual scientific meeting (ASM) in Melbourne.

As well as laying out the scope of domestic and family violence, and demonstrating its links to a host of adverse outcomes including sexually transmitted infections, unwanted pregnancy, preterm delivery, low birthweight and foetal or neonatal death, speakers made the case for obstetric and gynaecological doctors to walk with their patients as ‘safety allies’, and having strategies for women experiencing and at risk of violence and abuse.
Dr Richelle Douglas, medical director of Sexual Health Quarters (the trading name for the Family Planning Association of Western Australia), took out one of two best free communication prizes at the ASM for her impassioned presentation of a federally-funded screening pilot for intimate partner violence, the "astounding" findings of which she shared with delegates.

Douglas presented preliminary results from the study, which has not yet been published, showing that a staggering 1 in 6 participants had been subject to IPV and/or reproductive coercion, with 1 in 16 experiencing the latter alone and 1 in 7 the former.

Reproductive coercion is defined as behaviour that interferes with the autonomy of a person to make decisions about their reproductive health, such as contraceptive sabotage, pressuring another person into pregnancy, forcing another person to have an abortion or continue a pregnancy, and forcing a person into sterilisation.

Douglas found that 16 percent of people reported experiencing violence in their current relationship, and the same proportion (17%) accepted same-day appointments with a counsellor. One percent wanted same-day referral to a refuge.

These people were at 2.5 times greater risk of having a current unwanted pregnancy and 1.5 times more at risk of having a negative sexual health outcome, according to her study, which was funded by a grant from the Department of Prime Minister and Cabinet.

**Traumatic intersection**

In an interview with Croakey after her presentation, Douglas said:

"[There is] a very, very traumatic intersection between reproductive coercion and healthcare.

We know that two women a week are murdered by an intimate partner, we know that one in three women is exposed to physical violence from the age of 15, and one in five women has experienced sexual violence.

We have also seen in Australian data that intimate partner violence and reproductive coercion are a more significant risk factor than anything else for healthcare in women of reproductive age, and I think that it's something that – as practitioners – we don't always want to ask about because we feel like it's opening a can of worms."

For obstetric doctors, the imperative was clear, with demonstrated links to outcomes including preterm birth, low birth weight, admission to NICU, growth restriction, pre-eclampsia, labour and obstetric complications including caesarean section, and foetal and neonatal death.

This data was presented in a poster by University of Melbourne medical student Anita Stubbs. It also showed women who experienced IPV were more likely to suffer depression, anxiety, sleep disturbances, suicidal ideation and PTSD. Stubbs reviewed 32 studies on the topic dating back to 2002.

“Obstetricians and midwives need to be able to recognise and respond to women who have experienced intimate partner violence and abuse, and be aware of the potential medical complications that can arise as a result of the abuse,” Stubbs concluded.

This was the focus of a separate talk by Professor Kelsey Hegarty, director of the Centre of Research Excellence to Promote Safer Families, who – in keeping with the meeting's theme (Stop. Start. Continue) – urged colleagues to stop ignoring the issue, start asking women about it and continue responding to their needs.
Hegarty said what women wanted was simple: someone to listen, and a team to support them.

Contrary to the received wisdom that people experiencing violence and abuse in their relationship were reluctant to talk about it, Hegarty said it was overwhelmingly the case that women were relieved to be asked about it, to have their story heard, and to be validated.

See a Twitter summary of her talk.

Key screening questions

She had some important advice for health care workers, including the WHO’s LIVES framework for responding to intimate partner violence (Listen, Inquire about needs and concerns, Validate, Enhance safety, Support), and key screening questions under the acronym ACTS:

- Afraid: Has anyone in your family ever done anything to make you or your children feel unsafe or afraid?
- Controlled: Have they controlled your day to day activities or humiliated you?
- Threatened: Have they threatened to hurt you in any way?
- Slapped: Have they hit, slapped, kicked or otherwise hurt you in any way?

It was also essential to screen for immediate risk by asking if a person would feel safe when they left the consult, if they had any immediate concerns about the safety of children or other family members, and whether they would engage with a trusted person if they felt unsafe, she said.

Hegarty took colleagues through safety planning for anyone they identified as being at risk, which involved compiling a list of emergency numbers, helping to identify a safe place and a way to get there as well as family and friends who could provide support, and ensuring cash was available along with a safe place to store valuables and important documents.
She also explored barriers for healthcare workers in engaging with the issue, and strategies to address these using a stages of change model.

Hegarty closed with some key questions for healthcare workers to reflect upon in their own clinical practice.

For doctors, Douglas said the issue was often that questions about IPV were perceived as “intrusive”, and they were unsure what to do if someone disclosed that they had or were experiencing it.

In her own study, almost all the involved clinicians felt initially that such topics were not desirable to delve into.

However, after three months of using the pilot screening tool, Douglas said every single doctor felt “it had been really important to ask, and that it had significantly affected how they managed women and improved the outcomes of the women they had seen who had identified as being victims”.

**Empower women**

Douglas said:

“**One of the important things to recognise is that as a clinician we’re not there to solve the problem.**

We’re there to empower a woman to recognise that what’s happening to her isn’t right and she has the power, she’s a survivor, she can make a difference and actually improve her own outcome and that of her children.”

While screening for IPV did occur in most women’s health settings, Douglas said the issue was how it was being done, with the questions asked opportunistically, in public areas and in even in front of partners.

“I think what different care centres need to do is really think about how they are asking the questions, where they are asking the questions, and whether the woman feels safe to be able to disclose. Disclosure itself can be a really unsafe time for women,” she said.
Douglas called for RANZCOG to recognise IPV and reproductive coercion as significant risk factors for women’s health, particularly antenatally, with rates of violence known to increase dramatically during pregnancy, a “really vulnerable time for a woman and her unborn baby”.

“I guess the message for clinicians is that it’s easy, that you’ve got the skills to do it. We’re used to asking hard questions, but we need to know what to do with the answers as well. And often it’s just empowering women to be able to make their own decisions.”

See [this summary](#) of her presentation via Twitter.

**Watch our interview with Richelle Douglas**
Sharing powerful personal stories to encourage better support for doctors’ mental health

Dr Steve Robson presents to #RANZCOG19. Photograph tweeted by @BethSandford85

Amy Coopes writes:

As a group who had sacrificed so much – sometimes everything – for their profession, it was time for doctors to start investing in themselves, or patients would suffer.

These were the stirring sentiments shared in a powerful, intensely personal session at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ (RANZCOG) annual scientific meeting (ASM) in Melbourne, which put the mental health of doctors in the spotlight.

AFL Hall of Famer Merv Keane received a standing ovation after an emotional address about his daughter, Emily, who died in 2017, aged 36, following a protracted battle with alcohol addiction while training as a women’s health specialist with RANZCOG.

Little more than a month later, Merv’s wife Kaye took her own life.

“Our daughter Emily Keane was our gift to the world,” Keane told a packed auditorium of more than 1,000 delegates to the ASM. “More than a beautiful girl, she was a brilliant doctor. It was her personality to light up a room and a birthing suite.”
Keane, who had a storied career with the Richmond Tigers, shared the anguish of watching his daughter’s life and her drinking spiral out of control.

Fearing for her patients, he began following her to work at Melbourne’s Royal Women’s Hospital where, from across the road, he would witness her sneak out to a nearby bottleshop and purchase one, sometimes two bottles of vodka every day.

He was ultimately forced to report her to the Medical Board, resulting in restrictions on her registration as she further deteriorated, venturing out of bed only to drink and spending her days weeping.

“She would sometimes get better, but not for long,” said Keane. “In the end Emily couldn’t open her mail, do her shopping, pay her bills. Death was the only way she could find peace.”

“Emily didn’t deserve this fate. She deserved so much more.”

Systemic issues

While Emily’s issues were not exclusively linked to the pressures of specialist training, Keane said the intensity of the work and the personal attributes that had attracted her – and many of her colleagues – to a medical career, had played a role.

He had watched as his daughter and her fellow trainees became consumed by “bullying, stress, long hours, double shifts”, completely losing sight of the women and babies in their care. Their high-achieving personalities made it difficult for medical professionals to be vulnerable, he said, which was unsurprising but also meant it was difficult for their families to offer support.

“You have made enormous sacrifices and you must invest in yourselves,” Keane told RANZCOG delegates, many of whom were tearful as he spoke.

“Something, somewhere, somehow has let us down.”

While competition was healthy, Keane said things “can and do go wrong” and “none of us are bulletproof; we need to put our arms around each other.”
He also stressed the “power of proximity”, saying that those closest to the issues – not just the trainees but also those in positions of authority, including at RANZCOG – needed to acknowledge there were systemic and cultural problems at play, and to push for change.

“What is it about this carnage?” asked an emotional Keane. “Is it blame, or is it change?”

See this five-page summary of tweets from Keane’s presentation.

**Burnout, a patient safety concern**

Former RANZCOG president Steve Robson had set the scene for Keane’s keynote with an address examining the evidence for and imperative of addressing mental health in the medical profession.

Robson became somewhat of a spokesperson on the issue after a piece he wrote for the *MJA* last year about his suicide attempt as a junior doctor went viral, partly due to a heartfelt response written by fellow intern Kate Tree.

Robson told RANZCOG colleagues he had been prompted to write the piece during the pelvic mesh scandal when, as College president and very much the public face of the profession, he was on the receiving end of a great deal of anger, feelings of betrayal from patients and grief that began to take both a personal and professional toll.

After he was reported to AHPRA over one particular case (ultimately dismissed), Robson said he began to reflect on how significantly physician wellbeing could impact patients.

“Burnout, untreated mental health problems and other illnesses carry a considerable risk of imparting adverse outcomes on the patients for whom we care,” Robson said, adding that an “evolving body of evidence” supported this claim.
Unique pressures

Robson shared startling Australian data showing half of all doctors met the criteria for mental health problems like anxiety and depression or burnout, as well as overseas studies looking specifically at obstetrics and gynaecology and the prevalence of affective disorders, emotional exhaustion and suicidal ideation (a staggering 13 percent in one American study).

This predisposition was seen in medical graduates before they even started medical school, Robson added, questioning whether universities (and in their turn, specialist colleges) were selecting for personality types that were particularly vulnerable.

While all medical professionals were held to the highest standards, worked in an unremittingly intense emotional environment and were less likely to seek help and support for psychological problems, Robson said there were unique pressures for obstetricians and gynaecologists.

These included the unpredictability and length of work hours and the need to make snap decisions with very high stakes.

In Australia, Robson said mandatory reporting requirements posed a particularly significant barrier to disclosure and help-seeking for mental health issues, with a “cascade” of consequences including conditions on registration and practice and difficulties securing professional insurance.

See this summary of tweets from Robson’s presentation, and also the article mentioned below is here.
Supportive leadership

Vijay Roach, current president of RANZCOG, told delegates the College had failed trainees in the past with punitive and unsupportive approaches to mental health, and agreed that the organisation and its leadership had an important role to play.

“We want to grow trainees who feel supported, understood, cared for and empowered. We want RANZCOG to be a family that stands by you,” said Roach.

Roach told Keane the College also grieved Emily’s loss and stood with him in his determination that her death not be in vain.

He rejected approaches focused on the ‘resilience’ of trainees, an emphasis he said put the onus on a vulnerable individual while letting systems off the hook.

“I think that resilience is a term that we impose on other people so we can mask their suffering and make it easier for the rest of us,” said Roach, who has previously spoken out about his personal experience of PTSD and postnatal depression.

“Emily didn’t lack resilience.”

Sharing his own struggles with imposter syndrome and his personal relationships, Roach urged his colleagues to leave their inner perfectionist behind and “accept your frailties, your vulnerabilities, ask for and accept help”.

Instead of resilience, Roach called for a kind of radical acceptance from his colleagues that their profession was much more than a job, it was a vocation “and there are parts of it we cannot change”.

See this summary of tweets from Roach’s presentation.
Fund raising

Keane’s talk was titled ‘Emily’s Gumboots’, the name of an advocacy and training initiative he has launched on the welfare and wellbeing of junior doctors.

Emily was renowned at The Women’s for wearing fluorescent gumboots in the operating theatre, and Keane is now selling pairs of these boots to raise funds for his project.

He has already collaborated with RANZCOG’s Training Support Unit to develop a workshop for O&G trainees, using Emily’s story, and has delivered talks at The Women’s, Goulburn Valley Health and Eastern Health.

Watch our interview with Keane
You can track Croakey’s coverage of the conference here.

• Read our previous coverage of #MH4Docs, including at the Royal Australian and New Zealand College of Psychiatrists here and the Australasian College for Emergency Medicine here.

Reach out for support

Lifeline 13 11 14 www.lifeline.org.au

Suicide Call Back Service 1300 659 467 www.suicidecallbackservice.org.au

MensLine Australia 1300 789 978 www.mensline.org.au

beyondblue 1300 224 636 www.beyondblue.org.au
Where is the political will to save hundreds of thousands of women’s lives?

From Professor Lesley Regan’s presentation at #RANZCOG19. Photograph by Amy Coopes

Amy Coopes writes:

Some 300,000 women will die across the globe this year as a result of pregnancy and one-quarter of them will be adolescent girls, according to a leading obstetrician-gynaecologist from the United Kingdom.

Professor Lesley Regan, president of the Royal College of Obstetricians and Gynaecologists, said a staggering 90 percent of these deaths were preventable – with political will to address concerns such as unplanned pregnancy and unsafe abortion.

In a keynote address to the annual scientific meeting of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Regan made an impassioned case for her trans-Tasman colleagues to step up their political advocacy and shift their focus to preventing maternal deaths through contraception and safe abortion.

Regan, who is only the second-ever female president of RCOG and the first in 64 years, presented a stark picture of maternal mortality and the “elephants in the room” – contraception and abortion – in an address to RANZCOG delegates about progress towards sustainable development goal (SDG) 5.

One of 17 goals for global development over the next decade, which also includes taking urgent action to combat climate change and its impacts, SDG 5 commits countries to achieving gender equality and empowering all women and girls, something Regan described as an “enormous task”.

“Change the world”

Regan drew parallels with climate change, which was glaringly absent from the RANZCOG program despite evidence it will deepen gender-based health disparities, including access to sexual and reproductive health care.

Regan said action on climate change was just as important to women’s health and to society as abortion and contraceptive care, but the former was a problem on such an immense and complex scale that it invited a sense of helplessness.

“Whether we are talking about the importance of contraception and abortion care in underpinning women’s health and underpinning society — and so too does climate change and what we’ve effectively dumped on the next generation... I think so many times we are paralysed by these big discussions, and we think ‘what can I do about it, I’m too little to do anything on my own’,” she told Croakey in an interview after her address.

“My message today to that audience was if everybody in this room did one thing this week to improve gender equity, we would really change the world.”

While not the sole or definitive indicator of progress on this front, Regan said maternal mortality was a useful proxy for both the status of women globally, and of political commitment to the challenge.

The data was troubling, with 90 percent of the 300,000 maternal deaths that occurred across the world every year attributable to causes for which Regan said there were “cheap, heat tolerant interventions or drugs that could actually change those statistics”.

These included unsafe abortion, which accounted for 15 percent of all deaths and claimed the lives of eight women every hour, sepsis (16%), pre-eclampsia/eclampsia (13%) and haemorrhage (28%).

“We have to ask ourselves why it is that 90 percent of all maternal mortalities in the 21st century are potentially preventable,” Regan said in her address. “It’s because the societies in which they live have not yet decided that their lives are worth saving.”

Shocking inequities

While the lifetime risk of maternal mortality was about 1 in 7,000 globally, Regan demonstrated stark differences from country to country.

In highly developed Sweden, the best place in the world to have a baby, it was 1 in 17,400, rocketing to 1 in 22 for sub-Saharan Africa and a staggering 1 in 8 for women in Chad.

“In Chad if you’re a girl you’ve got more chance of dying because somebody got you pregnant than you have of finishing your secondary school, and I think in the 21st century that’s a pretty shocking statistic,” Regan said.
Every maternal death was a tragedy in and of itself, but Regan said maternal deaths were just the tip of the iceberg, with an estimated 30 women experiencing life-changing morbidity as a result of their pregnancy for every woman who died.

Maternal death and disability also had significant flow-on effects for families and communities, she said.

“If your mother died while giving birth to your sister or your brother, the chances of you getting to school, being vaccinated, having clean water, being educated properly would start to fall dramatically,” she said.

The “vast majority” of maternal deaths were among the estimated 225 million women worldwide who had no access to family planning, she said, calling for her colleagues to shift their focus upstream from “firefighting” in the birthing suite to preventing maternal deaths through contraception and safe abortion.

Regan said there were 75 million unplanned pregnancies and 22 million unsafe abortions across the globe every year.

Read more on the abortion discussions at #RANZCOG19 here.

Advocacy needed

Regan also impressed the importance of political advocacy, telling delegates: “I cannot emphasise enough the importance of influencing government.”

“I think it’s absolutely crucial,” she later told Croakey. “We’ve got to advocate for women and women’s health, because in so many parts of my own country and around the world, some of the most disadvantaged girls and women have got no voice of their own.”

She shared some examples showing how political conditions directly influenced the health of women, offering insights from Sri Lanka, India and Syria, where she said 65 percent of medical emergencies were obstetrics and gynaecology cases.

Ever the “incurable optimist”, Regan said she believed the world could meet SDG 5 by 2030, but it was essential to step up progress, particularly for her specialty.

“We mustn’t stop halfway,” said Regan. “If you’re talking about climate change, or if you’re talking about sustainable development goals, it’s just too easy to think ‘it’s too big, what can I do I’m only little me’.”

“But O&G professionals have this most unique position where, if they harness their expertise and their advocacy skills, they can have a real impact on girls and women throughout their life course.”

Regan shared this powerful video to conclude her talk: No Point Going Halfway.

See this 12-page Twitter summary of her presentation, as well as this Twitter thread by Dr Bec Szabo.
You can track Croakey's coverage of the conference here.

Congratulations to Professor Lesley Regan @lregon7 - RANZCOG Honorary Fellowship @RCObsGyn @RANZCOG_Pres #RANZCOG19

Where is the political will to save hundreds of thousands of women's lives?

#RANZCOG19

Political will not doctors is the key to maternal mortality - Prof Lesley Regan #RANZCOG19 @lregon7

Ensure gender equality and empower all girls and women.
Where is the political will to save hundreds of thousands of women’s lives?

You can track Croakey’s coverage of the conference here.

Prof Lesley Regan - if you care about mothers dying, you HAVE to care about #contraception and safe #abortion @lregan7 #RANZCOG19

Contraception is the single most cost effective measure in maternal health @lregan7 #RANZCOG19 @rcog @RCoG

A powerful start to the final day of #ranzcg19.

Prof Regan, President of RCOG and new Honorary Fellow of RANZCOG, with her final message to the crowd in achieving gender equality @lregan7 #SDG5
You can track Croakey's coverage of the conference here.

Watch our interview with Regan
(with the memorable quote that “opportunities don’t make appointments, you just have to grab them.”)

Where is the political will to save hundreds of thousands of women's lives?

Lesley Regan @iregan7 · Oct 14
What talented girlfriends I have the privilege of knowing. Thank you for your leadership and your contributions to women's health and empowerment @RCObstGyn @Fig0hq @ranzCog @iregan7

Nisha Khot @Nishaobgyn · Oct 13
Just some inspiring women who are in #Melbourne for #RANZCOG19
@iregan7 @RCObstGyn Second woman President ever, first in 64 years
Prof Christine Tippett @ranzCog Only woman President ever
Dr Gillian Gibson @ranzCog Only current Board FRANZCOG woman
#GenderEquity #WomenLeaders

Lesley Regan @iregan7 · Oct 16
It was a pleasure talking to a journalist who is so committed to promoting women's health. Thank you Amy @coopesdetat @RCObstGyn @iregan7

Amy Coopes @coopesdetat · Oct 16
Thank you to the formidable @iregan7, President of @RCObstGyn, for sitting down with @CroakeyNews at #RANZCOG19 to talk advocacy, SDGs, maternal mortality and the glass ceiling twitter.com/coopesdetat/st...
Some pointy questions for obstetricians and gynaecologists

In her final report from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ annual scientific meeting in Melbourne, Amy Coopes investigates some pressing questions for the specialty.

Amy Coopes writes:

What should you stop doing? What should you start doing? And what should you continue doing?

These were the pointy questions posed to obstetricians and gynaecologists at a recent specialty conference in Melbourne that was held with the theme Stop. Start. Continue.

As outlined below, the use of this theme, at the RANZCOG annual scientific meeting in Melbourne led to strong and wide-ranging recommendations across a range of fields, from clinical interventions to prevention, public health and patient-centered care.
You can track Croakey's coverage of the conference here.

Some pointy questions for obstetricians and gynaecologists

You can browse **the full list**, harvested from Twitter, but we’ve selected our top five Stops, Starts and Continues:

**STOP**
1. Talking exclusively about ‘health care’ and only listening to medical experts
2. Assuming we know what women want
3. Believing we can be good at everything, particularly when it comes to surgery
4. Putting certain topics in the too-hard basket or assuming they’re somebody else’s business (including trauma and violence, sexuality and contraception)
5. Believing the status quo is good enough.

**START**
1. Asking women what they think and listening to their lived experiences
2. Sharing what we know and what we don’t know with patients
3. Putting prevention and equity at the heart of our practice
4. Talking about health and the social determinants of health
5. Difficult conversations around the impact on patients of issues like ‘conscientious objection’ and remuneration models.

**CONTINUE**
1. Shared decision making and asking women and families what matters
2. Advocating for, and lobbying governments on, appropriate and affordable services and equity of access
3. Recognising the importance of investing time and resources and education/upskilling/competency in serving patient populations that most need your care (whether Aboriginal and Torres Strait Islander peoples, women using drugs and alcohol, women experiencing trauma and violence, CALD populations or trans patients)
4. Holistic, individualised, patient-centred approaches
5. Reviewing your outcomes, referring in the best interests of the patient, and striving for optimal outcomes for women and babies.

Read more about these issues in **our previous stories**.

Also see this 29-page **Twitter summary** of a “Tweetorial” by Dr Bec Szabo of her presentation with Dr Sarah Janseens on the use of simulation – an excellent example of the use of Twitter for knowledge exchange.

Her conclusion:

“We need to stop practising on patients. We need to start building expertise in RANZCOG educators. We need to continue to use simulation and build that into the continuum of our journey as RANZCOG doctors into the future.”
Some pointy questions for obstetricians and gynaecologists

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From Twitter

charlottetweets @inspectorcharl · Oct 16
So good to have education about #transhealth at our college meetings #RANZCOG19

Some pointy questions for obstetricians and gynaecologists

#RANZCOG19

Amy Coopes @coopesdetat · Oct 16
And a special nod to @RANZCOG_Pres #RANZCOG19

Anita @Anita__Stubbs · Oct 16
Austin research fest underway. Delighted to have two posters on display, following up from #ranzcg19 @Austin_Library @Austin_Health @AustinMRF1 a stunning lot of posters in the education precinct of Austin Tower. A fantastic community effort 🌟
You can track Croakey’s coverage of the conference here.

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Some pointy questions for obstetricians and gynaecologists

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Feedback

Marilla Druitt @MarillaDruitt  ·  Oct 16
Thank you to @CroakeyNews @coopesdetat RANZCOG staff, our wonderful volunteers and people who care about women’s health - the vibe was wonderful & lots of attendees report inspiration!
It was good :) @drjosaid @ranzcgog @RANZCOG_Pres

Dr Hilary Joyce FRANZCOG @drhilary_joyce  ·  Oct 16
While the meeting is still underway, a massive thanks in particular to @coopesdetat @inquisitiveGyn @NishaOBgyn and to @ranzcgog for a twitter sense of inclusion and ongoing education from afar #ranzcgog19

Tanya @GongGasGirl
Replying to @drhilary_joyce @coopesdetat and 6 others
Agree. Great tweeting. Learning plenty from here! #ranzcgog19

Dr Bec Szabo @inquisitiveGyn  ·  2h
Replying to @SezClom @CroakeyNews and @coopesdetat
As someone who did attend but could only be in one place at once ditto!!
Great to have been able to follow what’s happened across the conference AND we finally met in person. 💚彩虹 thanks superstar 🌟 @coopesdetat @CroakeyNews
You can track Croakey's coverage of the conference here.

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#RANZCOG19

For someone who couldn’t attend the RANZCOG ASM, a massive shoutout to @CroakeyNews for covering it and @coopesdetat for such a spectacular job.

5:02 PM - Oct 16, 2019 - Twitter for iPhone

5 Retweets 28 Likes

Lucie Robson @lucierobson - 44m
Replying to @SezClom @CroakeyNews and @coopesdetat
I liked the coverage too, as a med student just a few weeks into my O&G placement :)

Amy Coopes @coopesdetat - 43m
Hooray!

Nisha Khot @Nishaobgyn - 42m
Replying to @dhilary_joyce @SezClom and 3 others
I got to confuse @coopesdetat and it made the whole conference worthwhile for me 😊
#RANZCOG19
Analytics

During the period of Croakey’s coverage of the conference, Symplur analytics show that more than 4,900 tweets were sent using the hashtag by 640 Twitter participants, creating more than 41 million Twitter impressions.

Amy Coopes broadcast eight interviews live on Periscope, with a total 2,624 views as of 14 November. Watch the conference playlist here.

The #RANZCOG19 Influencers

<table>
<thead>
<tr>
<th>Top 10 Influential</th>
<th>Prolific Tweeters</th>
<th>Highest Impressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>@coopesdatat 100</td>
<td>@MelissaSweetDr 1,010</td>
<td>@MelissaSweetDr 24.4M</td>
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<tr>
<td>@ranz cog 98</td>
<td>@coopesdatat 872</td>
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<td>@inquisitiveGyn 85</td>
<td>@ranz cog 294</td>
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<td>@Asher_Wolf 646.6K</td>
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<tr>
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<tr>
<td>@AlyceWilson 53</td>
<td>@dhilary_joyce 53</td>
<td>@NIshobaGyn 266.5K</td>
</tr>
</tbody>
</table>

The Numbers

41,296M Impressions
4,944 Tweets
640 Participants
8 Avg Tweets/ Hour
8 Avg Tweets/Participant

Top 10 influencers is determined by the SymplurRank algorithm.

#RANZCOG19 Participants

Data for #RANZCOG19 can be up to 15 minutes delayed

Croakey Conference News Service

- Reporting by Amy Coopes
- Editing by Melissa Sweet
- Layout and design by Mitchell Ward